617.23-00
J82
2



Library
of the
Academy of Medicine,
Toronto.
1227
Presented by
R. A. Reeve Fund
1921

Vol. II. JANUARY, 1888. No. I.

AMERICAN EDITION.

THE JOURNAL

OF

LARYNGOLOGY

AND

RHINOLOGY

AN ANALYTICAL RECORD OF CURRENT LITERATURE RELATING TO

THE THROAT AND NOSE

EDITED BY

SIR MORELL MACKENZIE, M.D. Lond.

AND

R. NORRIS WOLFENDEN, M.D. Cantab.

WITH THE CO-OPERATION OF

DR. G. HUNTER MACKENZIE (EDINBURGH)
DR. FAUVEL (PARIS)
DR. JOAL (MONT DORE)
PROF. MASSEI (NAPLES)
PROF. GUYE (AMSTERDAM)
DR. CAPART (BRUSSELS)
DR. CONSTANTIN KARWOWSKI (WARSAW)
DR. MICHAEL (HAMBURG)
PROF. RAMON DE LA SOTA Y LASTRA (SEVILLE)
DR. HOLGER MYGIND (COPENHAGEN)
DR. SMYLY (DUBLIN)
DR. DAVID COLLINGWOOD (SYDNEY)
DR. G. W. MAJOR (MONTREAL)
DR. MAXWELL ROSS (EDINBURGH

AND

DR. JOHN N. MACKENZIE
for America

LIBRARY
OCT - 4 2001
UNIVERSITY OF TORONTO

Published Monthly

LONDON
R. ANDERSON & CO.
14, COCKSPUR STREET,
CHARING CROSS, S.W.

PHILADELPHIA
P. BLAKISTON, SON & CO.
1012, WALNUT STREET

PRICE ONE SHILLING.
Prepaid Annual Subscription, Twelve Shillings, or Three Dollars.

THE BURROUGHS CHLORIDE AMMONIUM INHALER.

(VEREKER'S PATENT.)

"It is the best Inhaler I have ever used, and I think I have tried all the different Chloride of Ammonium Inhalers hitherto devised."—Dr. FRANKS, Dublin University.

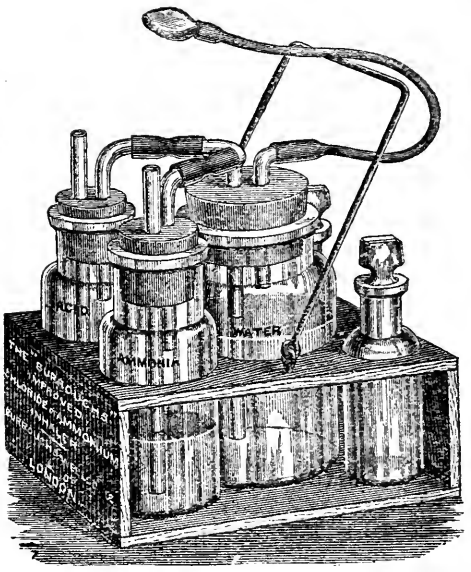
"It is the best Inhaler for Chloride of Ammonium I have met with."—Dr. SMYLY, Ex-Pres. Royal College of Surgeons.

AN IMPROVED APPARATUS.

The advantages afforded by this Inhaler are, that it is easy to prepare, and for weeks and months is always ready for use; that the fumes are neutral, and that any one can use it without trouble. The fumes it yields are unirritating, and exert a truly wonderful action upon thickened mucous membrane, and thick tenacious secretion. The objections raised against the ordinary Chloride of Ammonium Inhalers have been such as would deter most practitioners from recommending one of them a second time. As a rule, they have to be specially prepared for each time of using, fresh acid and ammonia being required; there is no means of regulating the acidity or alkalinity, so that perfect neutrality of the fumes is uncertain. They easily get out of order, and if not manipulated with considerable skill may do much harm by the irritant effects of the vapour generated.

The BURROUGHS AMMONIUM CHLORIDE INHALER, a cut of which is given in the next column, is of such ingenious construction that it requires no skill whatever to handle it.

It will be observed that the currents of air drawn through the acid and ammonia meet, and form a vapour of Ammonium Chloride before being drawn through the water, and so the fumes are washed and neutralized. The specific effects of Chloride of Ammonium on the respiratory membrane have long been known, but the drawback has been that, on account of an excess of acid or alkali the fumes were apt to prove irritating. By passing them through water, as in the Burroughs Improved Inhaler, this fault is now completely overcome, and perfect purity made certain. There is not the slightest difficulty in preparing the Inhaler for use, and the benefits it confers are immediate, as every portion of the mucous membrane of the respiratory tract may be locally treated by the medicament coming in contact with it.



If used as a cold is coming on, it is said that Ammonium Chloride Vapour will often break it up, and that in catarrhal affections which have become *settled* the Inhaler should be used frequently.

The full benefit of any volatile medicament, as Terebene, Pinol, or Eucalyptine, may be secured by the addition of 5 or 10 drops to the water in the large bottle.

In an admirable article in the *Lancet*, of February 12, 1887, Dr. Kendal Franks says:—"In chronic catarrh of the post nasal region, so frequently associated with deafness, due either to chronic otitis media or to obstruction of the Eustachian tubes, I have found the regular use of the Inhaler for weeks or even months give the most satisfactory results. . . . . When the Eustachian tubes are obstructed, so that air cannot be forced through them by Valsalva's method, the occasional use of Politzer's bag during the earlier treatment will usually suffice."

A reprint of Dr. Frank's article will be sent post free to any physician on request.

The Vapour of the Chloride of Ammonium removes unhealthy and offensive secretions, and restores the long diseased or weakened nasal and respiratory mucous membrane to a healthy state, so that in cases of catarrh, where thickening, induration, and irritation exist, a most decided improvement is brought about in a short time. In "throat-cough," pharyngeal irritation, and relaxation and weakness of the throat, it acts as a most effective local alterative and tonic to the mucous membrane.

Dr. Ringer says:—"Ammonium Chloride is indicated in chronic bronchitis when the secretion is thick and abundant, and may be applied topically to the morbid mucous membrane *by means of the Inhaler.*"

BURROUGHS, WELLCOME & CO., SNOW HILL BUILDINGS, E.C.

CONTENTS.

Original Articles.—Report upon Leprosy in Europe (*continued*), SIR MORELL MACKENZIE, p. 2. On Extirpation of the Larynx (*continued*), R. NORRIS WOLFENDEN, p. 8.

New Instruments and Therapeutics, p. 13.—MAW, SON, & THOMPSON: New Forceps. H. M. JONES: Antiseptic Cigarettes. WOLLERING: Iodol a Substitute for Iodoform. SHOEMAKER: Collinsonia Canadensis. CARTWRIGHT-REED: Climate in Phthisis. SAVILL: Algiers and its Climate. ILLINGWORTH: Biniodide Treatment of Scarlet Fever. The Treatment of Scarlet Fever. LANCET: Treatment of Scarlet Fever. Influence of Temperature on Mortality Rates. HOLLOWAY: Nasal Insufflations in Whooping-Cough. LOWE: Benzol in Whooping-Cough. LYNCH: Ibidem. KRÜNKE: Cocaine in Whooping-Cough.

Diphtheria, p. 17.—JOHANSSEN: Prophylactic against Diphtheria. MERCIER: Chloral in Diphtheritic Angina. SNOW: Sulphurous Acid in Diphtheria. ILLINGWORTH: Mercury Biniodide in Diphtheria. MAIN: Ibidem. MOLONEY: Arsenic in Diphtheria. ROESE: Turpentine in Diphtheria. SMITH: Diphtheria. CASADESUS: Diphtheritic Pharyngo-Laryngitis. BARRET: Diphtheria Circumscripta. FRASER: Ibidem. ATKINSON: The Causes of Diphtheria.

Nose and Naso-pharynx, p. 19.—ROTH: Diseases of the Mucous Membrane. REIMANN: Micro-organisms in Nasal Secretion. RICHARDSON: Paroxysmal Sneezing. GRAHAM, HAILES, WILLIAMS: Ibidem. WALKER: Removal of Foreign Bodies from Anterior Nares. ANONYMOUS: Caterpillar in the Nose. CAMPBELL: Plastic Operations. NATIER: Deviations of the Nasal Septum. ALVIN: Hot Water Irrigations in Epistaxis. STORCH: Rhinoscleroma.

Mouth, Tonsils, Pharynx, p. 20.—ZILM: Pathology of the Lips. SCHRAKAMP: Diagnosis of Diseases of the Mouth. MONOD: Adhesion of Palate to Pharynx. DURET: Palatine Angioma. LUBLINSKI: Concretions—Polypus. FERRÉ: Pharyngo-mycosis. WRÓBLEWSKI: Pharyngeal Tuberculosis. WILD: Action of Quinine in Muscles of Œsophagus. BRIDGMAN: Toothplate in the Gullet for Fifteen Months. JOZEFCZYK: Œsophageal Cancer.

Larynx, p. 23.—LANDGRAF: Affections of the Larynx in Croupous Pneumonia. LEWIN: Laryngeal Perichondritis. CHARAZAC: Sulphur in Laryngeal Tuberculosis. PRZEBÓRSKI: Treatment of Laryngeal Phthisis. WRÓBLEWSKI: Large Papilloma. MACDONALD: Intra Laryngeal Abscess. DELONTAINE: Inter-crico-thyroid Laryngectomy. SOKOLOWSKI: Syphilitic Tracheal and Bronchial Stenosis. BLAU: Tamponnading the Trachea. HANOT: Cervico broncho-tracheal Œsophagotomy. Perforation of Œsophagus and Trachea, &c.

Neck, p. 26.—MORRIS: Two cases of Thyroid Disease. OECHLI: Strumectomy. OBOLINSKY: Surgery of Goitre. KOHLER: Communications from Bardeleben's Clinic. LUCY: Leucoderma in Graves's Disease. WORNER: A Case of Determined Suicide. ALEXANDSHAW: Etiology, &c., of Whooping-cough. ASTIER: Suppuration of the Maxillary Sinus. MULLER: Uterine Cough. BARRON: Skin Staining with Silver. BASTIAN: On Aphasia. MILLIGAN: Poisoning by Nitric Acid. HEDINGER: Report.

Association and Congress Meetings, p. 29. Sixtieth Meeting of German Naturalists and Physicians. Ninth International Medical Congress. Papers by Drs. O'DWYER and MAX J. STERN on Intubation.

Reviews, p. 45. CHIARA: Observations on Diseases of the Throat and Nose. HERING: The Curability of Laryngeal Phthisis by Surgical Methods.

Notes, p. 47.—A Correction. The Index.

11227

The Pine Treatment.

FOR BRONCHIAL, RHEUMATIC, GOUTY, NEURALGIC, AND RENAL TROUBLES.

LONDON.] JANUARY. [1888.

Pinol.

The Distilled Essence of the Pinus Pumilio.

The efficacy of the pine treatment has already received the recognition and endorsement of many of the most distinguished therapeutists of Europe, and it is being extensively adopted in Homburg, Ischl, Baden-Baden, Reichenhall, and other of the principal health resorts of the Continent, where the pumilio pine is used in one form or another. The opening of the New Hydropathic Institution at Farnborough the other day is another evidence of the growing favour of the pine treatment in disease. In this institution Pinol is used. Pinol is the pure essence or volatile oil distilled from the needles of the Pinus Pumilio, growing in the perpetual snow of the Alps. It is distinguished from the common pine oils by superior medicinal and sanitary properties, and by its exquisite fragrance.

MODES OF EMPLOYING PINOL.

Pinol is used as an Inhalation, a Gargle, an Embrocation, for Fumigation, and internally.

Inhalation.

For purposes of inhalation it may be used in the *Pinol steam atomizer*, a spray apparatus, or the Burroughs Ammonia Inhaler. Inhalations of Pinol have an extended sphere of usefulness, inasmuch as they are applicable to cases of catarrh, ozena, cold in the head, gravedo, sore throat, tonsillitis, hoarseness, aphonia, asthma, chronic bronchitis, bronchorrhœa, and phthisis. Where an Inhaler is not at hand, the entire respiratory tract may be medicated with the drug as follows :—Add thirty minims of *Pinol* to ½-pint of boiling water in a basin, stir, and mix with ½-pint more boiling water. Confine the vapours by covering the head and surrounding the basin with a towel, and inhale for 3 or 4 minutes. Repeat several times daily.

Chloride of Ammonium Inhaler.

It is alleged that at the health resorts even the gouty and rheumatic, though free from chest complaints, are benefited by inhalations of Pinol. Thirty minims may be dropped into the *Pinol steam atomizer* or the water-bottle of the *Burroughs Inhaler.*

Internal administration.

Public speakers, singers, elocutionists, actors, etc., have found that the employment of Pinol inures the throat to trying conditions, and strengthens the voice. It may be taken in water or on sugar, in doses of 3 to 4 minims, or more agreeably in the form of our *Pinol Pastilles.*

Gargle.

Pinol also serves as a very useful gargle, and for this purpose 10 or 15 minims should be poured into ½-pint of boiling water.

Fumigation.

Another mode of employing Pinol is in fumigation. Pinol may be poured on a porcelain plate and allowed to gradually perfume the atmosphere, or evaporated by means of a spirit lamp; by the latter means the vapours are thus more quickly diffused throughout the room. It is highly praised for the phthisical.

External application.

Pinol is advantageously applied externally in cutaneous diseases, gouty and rheumatic joints, muscular rheumatism, and as an embrocation for sore throat and chest affections. It is also valuable in peritonitis, and sometimes in pneumonia, in fomentations (made by pouring a few drops on to flannels wrung out of hot water), which are to be frequently renewed.

Pinol is supplied in bottles at 2s. 6d. and 4s. 6d. retail, and at 2s. and 3s. 9d. to the profession. Also in the form of Pastilles. The Pinol steam atomizer sells at 10s. retail, and at 8s. 6d. to the profession, and the Burroughs Inhaler at 10s. retail, and at 7s. 6d. to the profession.

BURROUGHS, WELLCOME, & CO., Snow Hill Buildings, London, E.C.

THE

JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. JANUARY, 1888. No. 1.

EDITORS' NOTICE.

WITH the appearance of the second volume of this Journal, the Editors cannot refrain from expressing their pleasure at the manner in which the new venture has been received by the medical public. The cordial support which has, from the first, been extended to the *Journal of Laryngology*, both in this country and in America, has encouraged the Editors to make some additional changes in the conduct of the Journal, which they venture to think will add to its usefulness. An English edition will be published simultaneously with an American edition, the former being in the future in the hands of Anderson & Co., of London, the latter being undertaken by Blakiston, Son, & Co., of Philadelphia, as heretofore.

All abstracts will in future be printed in smaller type, thus enabling the Editors to include several additional pages of matter in each number.

As heretofore, one original article will be published every month in the Journal, but instead of such articles being editorial, they will in future be contributed by well-known laryngologists in all parts of the world.

It is requested that all editorial communications be addressed to the Editors of the *Journal of Laryngology*, at the London Office, 14, Cockspur Street, Charing Cross, S.W., and that all business and advertisement communications be addressed, Manager, *Journal of Laryngology*, at the same address.

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés *d'envoyer un numéro de tout journal* contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Um die rechtzeitige Veroffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

A REPORT UPON LEPROSY IN EUROPE (PARTICULARLY AS IT AFFECTS THE AIR-PASSAGES).

(*Continued from* Vol. I., *page* 365.)

My observations in Norway were made in the early part of the autumn of 1884. I first visited the hospital at Molde, where the physician in charge, Dr. Kaurin, courteously guided me over the whole building, and allowed me to examine such patients as I wished. The hospital is beautifully situated, standing in its own grounds somewhat above the level of the town, looking over the Molde Fjord. The number of patients at the time of my visit was 56—33 men and 23 women—but there is room for many more. They are kept at the expense of the State as long as they live, but no hindrance is offered to their leaving the hospital if so minded; only one or two, however, avail themselves of the privilege in the course of the year. Dr. Kaurin informed me that there are several cases among well-to-do persons in the neighbourhood of Molde; the sufferers live with their friends, who try to hide their condition as well as possible. The following table gives a summary of my observations at Molde:—

MALES.

	Age.	Remarks.
1	66	Slight swelling of arytænoids. A little swelling of vocal cords. Nothing characteristic.
2	54	Tubercles. Swelling of epiglottis—especially on dorsum. Tubercles on palate. Uvula gone, leaving thickened stump. Ulcers on pillars, especially left side. Swelling of ary-epiglottic folds and ventricular bands.
3	26	Tubercles on epiglottis and uvula. Father and mother leprous. Five brothers and sisters healthy.
4	24	Mucous membrane of mouth anæmic and thickened. Uvula partly wasted. Tubercles at base. Thickening of epiglottis and arytænoid cartilages.
5	29	Uvula shortened, almost as if cut across. Septum nasi thickened posteriorly. Immense thickening of epiglottis. Uncle leprous.
6	57	Bad case. Horrible smell. Eyes gone. Anæmia and atrophy of whole pharynx. Tubercles on tongue. Deep pocket between anterior and posterior pillars, with ulceration at bottom (left side). (Mucous membrane of posterior pillar much developed.)

I saw only one woman at Molde: she had a large ulcer on the palate, the uvula was eaten away, and there was much thickening round the upper laryngeal orifice.

At Bergen, which may be called the head-quarters of "spedaljkhed" in Norway, there are three hospitals for lepers—S. Jörge, Lungesgaard, and the Central—all standing close to each other, a little way out of the town, but in a public thoroughfare with houses on each side. At the time of my visit there were 68 patients in the S. Jörge, 76 in the Lungesgaard, and 157 in the Central, making a grand total of 301, of whom 158 were women. In spite of this abundance of material, I had less opportunity of making satisfactory examinations here than at Molde, as all three hospitals were overrun with enthusiastic inquirers of various nationalities who had come up from the Copenhagen Congress. Dr. Nicoll, of the Central Hospital, was, however, kind enough to place some patients with laryngeal symptoms at my disposal; but as each case had to be looked at in company with six or seven other eager students, the examination was necessarily hurried and incomplete. I may add that we had only the rays of the sun to trust to for the illumination of the throat, but as the day was fortunately bright this did not matter very much. I have no special notes of the individual cases examined, but in all the appearances were much the same, viz., pallor, and thickened glazed look of the mucous membrane of the mouth and throat; destruction, more or less complete, of the uvula; tubercles on the tongue, palate, and (in one or two cases) on the posterior wall of the pharynx; thickening, with or without ulceration, of the epiglottis and arytænoid cartilages. Owing to this, it was exceptional to be able to see the interior of the larynx. In our hurried scamper through the wards I noticed two or three patients wearing tracheotomy tubes, and in very many cases a characteristic deformity of the nose caused by the falling in of the bridge. In the Lungesgaard Hospital I had the advantage of seeing a splendid preparation of the *bacillus leprae* put up, and most kindly demonstrated by Dr. Armauer Hansen, the discoverer of the parasite. I must also record my indebtedness to this indefatigable worker for much information as to the etiology, pathology, and statistics of the disease. From the venerable Danielssen, also, I received some valuable hints as to certain features of the disease, to the elucidation of which he has devoted a long life-time, and for kindly showing me some specimens of the leprotic larynx, which, from their look of hoary antiquity, were probably the originals of Plate *V.*, *b* and *c* in his splendid Atlas.

I had no time, unfortunately, to visit Throndhjem, near which there is a village named Reitgjerdel, where there is a leper hospital with 150 patients.

On the occasion of a recent visit to San Remo, I visited the

Leper Hospital. This institution used to contain ten or a dozen patients, but latterly there have seldom been more than two or three. Cavaliere Ajardi, chief physician to the hospital, who kindly showed me the cases, attributed the diminution in numbers to the loss by Italy of Nice and its surroundings. This district formerly supplied the greatest number of leprous patients; but since it has become French the cases are sent to Paris. When I visited the hospital there were only two leprous patients, a man and a woman. The male patient was aged twenty-eight years; he had suffered from skin disease for four years, and had general thickening of the skin of face, and numerous warty growths were present in this situation. He had hoarseness of two years' standing; the epiglottis and arytenoid cartilages were found to be thickened, and there was an ulcer on the left side of the first and over the left arytenoid cartilage. The mucous membrane of the pharynx and larynx had a very anæmic appearance.

The woman was aged thirty-five years; she had been suffering from general symptoms of leprosy for eight years; her voice, which was reduced to a hoarse whisper, had first become affected two and a half years ago. Her breathing was decidedly stertorous. Examination of the throat showed great thickening of the palate and uvula, whilst the epiglottis was so swollen that it was impossible to obtain a view of the interior of the larynx.

The general course of leprosy in the throat and air-passages must now be described. I have already given elsewhere[1] an outline of the principal changes observed in these parts, and the present account will be little more than an amplification of the details there given. I am not aware that the throat is ever affected in the macular variety of the disease, nor does this complication occur, as a rule, in the purely anæsthetic form. Hansen has, however, described a case in which there were redness and swelling of the whole throat and upper air-passages coinciding with an acute eruptive affection of the skin; the attack was of a merely temporary nature, but some roughness of voice remained.[2] In tubercular leprosy, on the other hand, it is probable that the throat is attacked, sooner or later, in nearly all cases. As already said, the throat affection is invariably secondary to the skin complaint. It usually occurs at a comparatively advanced stage of the disease, though occasionally it may come on, as in a case observed by myself in Seville, almost at the beginning. The voice becomes hoarse or nasal, then shrill, gradually

[1] *Manual of Diseases of the Throat and Nose*, vol. i. London, 1880, p. 308, *et seq.*

[2] *Nordiskt Medicinskt Arkiv.*, vol. ii., No. 16, 1870.

losing resonance, till it is altogether lost, and the patient can only speak in a faint whisper. Breathing through the nose becomes difficult, and as the laryngeal orifice becomes more and more stenosed a certain degree of dyspnœa is felt, but the narrowing process is so gradual that the symptom rarely becomes urgent. It is in comparatively few instances that tracheotomy is required, though the breath-passage may be found after death reduced so much as hardly to admit a straw.[1] I was informed by Dr. Kaurin, of Molde, however, that in his experience rapid œdema of the glottis is not very uncommon, the patient dying of suffocation if help be not immediately at hand. The progress of the disease within the throat is rather less chronic than that of the cutaneous affection, ulceration occurring more readily, and the tuberculous infiltration taking place somewhat less slowly. In the throat, however, as in the skin, the complaint progresses by fits and starts, as it were, the exacerbations occurring at irregular intervals, but being usually ushered in by some degree of systemic disturbance and synchronizing with some "fresh developments" on the outer surface. The objective signs first noticeable in the throat are merely those of severe general congestion; after a variable period of time this is followed by the appearance, at different points, of small red papules ranging in size from a pin's head to a split pea. These at first are red in colour and soft, but gradually change to a yellowish-white hue, and become larger and harder. The parts first attacked are the follicles at the root of the tongue and in the pharynx, where the distended pouches are as prominent as swollen Peyerian patches in the small intestine. Tubercles may be seen on the dorsum of the tongue, often coalescing to form large masses on its surface, which is glazed and discoloured and marked by deep transverse fissures, which give rise to much pain. Larger and flatter tubercles can be observed on the roof of the mouth and velum palati; the uvula is hardly ever spared, being in some cases thickened and elongated, in others eaten away by ulceration. One of the differences I noticed between the disease as seen in Seville and the Norwegian type, was that whilst in the former gigantic hypertrophy of the uvula was the rule, in the latter it was exceptional to see anything but a mere stump in its place. The posterior wall of the pharynx is usually considerably ulcerated; sometimes, however, it is occupied by one or two large flat tubercles. In recent cases it is congested and succulent, but in those of older

[1] One of the specimens shown to me by Dr. Danielssen literally answered the above description. See also his work already referred to, p. 400.

standing it has the pale, yellow, thickened, glazed look, that characterizes the whole of the mucous membrane of the mouth and throat, an appearance which might almost suggest that all the parts had been infiltrated with tallow. The ulcers have a more or less circular outline, but without any elevation of the edge; the base is uneven and generally dry, the granulations being small, weak, and of a dirty grey colour; healing, however, as a rule, takes place after a certain length of time, and adhesions to neighbouring parts, *e.g.*, the soft palate, may be developed as after syphilitic ulceration. The pillars of the fauces, more particularly the posterior one, are frequently thickened and become very prominent, so as to make the space between them seem deeper than natural. I did not observe any change in the tonsils.

In the larynx the part most conspicuously affected is almost always the epiglottis, which is irregularly thickened and broadened; in most cases the enlargement is of a solid nature, and is due to infiltration of tuberculous material, but sometimes there is, besides, considerable œdema; in the former case it has the dirty white look already mentioned, in the latter it is dusky red and tense in appearance. Sometimes tubercles are seen on it, especially on one or other of the lateral edges, and frequently there is a considerable amount of superficial ulceration, but seldom any actual loss of substance. I have, however, seen one case in which the whole epiglottis had been eaten away, a narrow irregular fringe of ragged tissue being all that was left to mark its whereabouts. Similar changes affect the other parts of the larynx, notably those forming the boundaries of its upper orifice, the arytænoid cartilages, with the fold between them, and the ary-epiglottic folds; tubercles may sometimes be observed on the cords themselves, and there is always some ulceration of their surface as well as thickening of their substance; this leads to deficient approximation, whilst the infiltration of the surrounding parts (often extending into and filling up the ventricles themselves) interferes with their mobility. As a consequence of these various processes of infiltration with tuberculous matter, ulceration and healing, all the tissues become in course of time so matted together as to form a sort of homogeneous whole, in which the separate structures are almost lost, and the larynx is transformed into a more or less rigid tube of gradually narrowing calibre. Small tubercles are occasionally found in the trachea or bronchi, and much more rarely in the lungs; but as Danielssen and Boeck point out,[1] the pulmonary tissue is not a favourite site of the disease. They are even disposed to believe that leprosy counteracts any other diathesis (*e.g.*, phthisical) that may exist.

[1] Danielssen and Boeck: *op. cit.*, p. 222.

The gullet is, so far as I am aware, never attacked. The cervical and bronchial glands are often enlarged and indurated; but this occurs only when the disease is of long standing.

The nose suffers severely, both externally and inside. Tubercles form on the septum and the outer wall of the fossa, which very quickly ulcerate; obstruction of the passage is an early symptom, rendering the voice "nasal," and impairing or destroying the sense of smell. Epistaxis is frequent, being sometimes the first sign that the interior of the nose has been attacked. As the disease gains ground, perforation of the septum takes place, and in some instances more or less complete destruction of the bony skeleton, leading to great deformity.

As a general rule, comparatively little pain is experienced, even when the throat is extensively diseased. In most cases there is even a certain degree of anæsthesia, though never so complete as in the skin.[1] Open ulcers, however, are, as might be expected, sensitive enough, and there is sometimes a good deal of pain in swallowing from this cause. It is wonderful, however, how slight this often is, even in cases where the whole mouth, tongue, palate, and fauces, as well as the pharynx, are extensively involved. The sense of taste is a little blunted, but annulled only in the worst cases.

The minute morbid anatomy of leprosy, as it affects the throat, has recently been elucidated by two thoroughly competent observers, Masini of Genoa, and Thin of London.[2] Both agree that the thickening is mainly in the sub-mucous tissue, and that it is constituted partly by infiltration with leprous elements, partly by œdema, and partly by increase in the connective tissue. The epithelial layer is, as a rule, perfectly normal, except where it is wanting over an ulcerated surface. The cartilage also is, as a rule, unaffected, even when the morbid action reaches close to it. The essential feature is the presence of masses of cells of varying size, and more or less rounded in shape, each containing from one or two to a great many lepra-bacilli. These cells are, in all essential points, identical with the white corpuscles of the blood. They are often seen clustered round blood-vessels, and it is most probable, as suggested by Thin, that they are in fact leucocytes, which have somehow become infected, *i.e.*, made the recipients of the parasite (*bacillus lepræ*), and are carried by the current of the circulation to various parts, escaping through

[1] I am not aware that the sensibility of the mucous membrane of the throat has been tested in cases of pure anæsthetic type.

[2] Masini: *Bollettino delle Malattie dell' Orecchio, della Gola e del Naso*. November 1, 1884. Thin: *Brit. Med. Journal*, July 19, 1884.

the walls of the containing vessels, and in turn infecting other cells. In Masini's two cases, the nerves were all enlarged, except the superior laryngeal, and contained bacilli among their fibrillæ. The epidermis, epithelium, and cartilage are spared, owing to the fact of their being non-vascular, but it is difficult to understand how parasites, existing in such abundance and multiplying so rapidly, are not carried with the blood into all parts of the body. Their preference for certain parts and almost absolute avoidance of others seems to show that a certain soil and climate—in other words, certain qualities, chemical or physical, in the tissues—are necessary for their growth. The neoplasms press on the structures, muciparous glands, blood-vessels, nerves, and muscular fibres, among which they lie, causing atrophy. The destruction of the glandulæ explains the dryness already referred to as characteristic. The obliteration of the vessels accounts for the anæmia and pallor of the parts, whilst the compression of the nerves explains the want of feeling.

Morell Mackenzie.

ON EXTIRPATION OF THE LARYNX.

(*Continued from* Vol. I., p. 451).

PARTIAL or unilateral extirpation of the larynx has not been performed nearly so often as the major operation of total ablation.

Billroth first demonstrated the practicability of the lesser operation in 1878. His patient lived for sixteen months, possessed of a loud but hoarse voice and with good powers of deglutition, but died eventually in 1879 of recurrence of the disease. Hahn, who divides the honour with Billroth of having performed the greatest number of operations for ablation of the larynx, lays down the following rules for the consideration of unilateral extirpation.

This operation may only be indicated by the following conditions:

1. *Recurrent papilloma*, in which other methods previously tried have been unsuccessful.

2. *Stenoses and laryngeal strictures*, which incision or dilatation has failed to relieve.

3. *Malignant tumours* which are limited in extent and which have not affected the cartilages or neighbouring tissues; and more especially those superficial cancers (or "cancroids") which develope slowly.

Unilateral or Partial Excision.—I. For Cancer.

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. Billroth	M.	50	7 July, 1878	Unilateral epithelioma	Left half of larynx and part of right vocal cord	Died Nov., 1879, having had recurrence six months after operation
2. Keyher	M.	57	9 March, 1880	Carcinoma	Extirpation of left half of larynx	Cured. No relapse fourteen months after
3. Billroth	M.	65	11 Feb., 1881	Carcinoma of pharynx and larynx	Extirpation of right half of larynx and pharynx	Death from septicæmia five weeks after
4. Schede	M.	42	19 Oct., 1882	Epithelioma	Extirpation of right half of larynx	Alive in April, 1884
5. Wagner	M.	53	22 Feb., 1883	Epithelioma	Extirpation of right half of larynx and first ring of trachea	Death from collapse on twelfth day
6. Hahn	M.	54	11 Aug., 1883	Carcinoma	Extirpation of half the larynx	Sixteen months without recurrence, which, however, took place in 1884 in the wound. Death ten days after second operation
7. Billroth	M.	60	8 Nov., 1883	Epithelioma of epiglottis and cervical glands	Excision of epiglottis and superior third of thyroid cartilage	Death five weeks after from pneumonia without local recurrence
8. Billroth	M.	60	25 June, 1884	Epithelioma	Extirpation of right half of thyroid and cricoid cartilages and portion of left vocal cord	Was well in October, 1884, but obliged to wear a canula
9. Billroth	M.	58	15 July, 1884	Carcinoma	Extirpation of right half of larynx, pharynx, and infected glands	Recurrence Sept. 9, 1884, afterwards invading glands
10 Billroth	M.	46	6 Sept., 1884	Carcinoma	Partial extirpation, leaving the cricoid	Reported cured October 31, 1884
11. Hahn	M.	53	3 Nov., 1884	Carcinoma	Partial excision, leaving a part of the (right) thyroid and the whole cricoid cartilage	Death four days after of pneumonia or mediastinitis
12. Stoerk	M.	—	1885	Epithelioma	Partial extirpation of thyroid cartilage	April 24, 1885, said to be well (living in November, 1887)
13. Bergmann ...	M.	46	1885	Carcinoma	Partial extirpation	Living in 1886
14. Billroth	—	—	18 Dec., 1885	Carcinoma	Ablation of half larynx	Result unknown

UNILATERAL OR PARTIAL EXCISION.—I. FOR CANCER.—(*Continued*).

	Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
15.	Pick	—	—	1886	Carcinoma	Ablation of mucous membrane without cartilages	Death, four and a half months after
16.	Koller	—	—	1886	———	Extirpation of part of larynx	Nothing known
17.	Koller	—	—	———	———	Ditto	Nothing known
18.	Socin	M.	56	16 Mar., 1886	Carcinoma	Extirpation of 2nd half May 26	Death June 9, 1886
19.	Hahn	M.	52	3 May, 1886	Epithelioma	Partial extirpation	Well November, 1887
20.	Butlin	M.	50	26 June, 1886	Epithelioma of left cord	Ext. with forceps, recurrence, partial extirpation	Living November 12, 1886
21.	Lennox Browne ...	M.	61	15 Dec., 1886	Epithelioma	Left half thyroid and ericoid cartilages, left arytenoid and vocal cord	Well November, 1887
22.	Kraske	—	—	———	Carcinoma	Partial excision	Recurrence in sixteen months
23.	Kraske	—	—	———	Carcinoma	Partial excision	Recurrence in four months
24.	Mickulicz... ...	—	—	———	Carcinoma	Partial excision	Reported cured at end of a year
25.	Péan	M.	53	April, 1887	Epithelioma	Partial excision	Recurrence fifteen days after. Death from strangulated hernia six hours after
26.	Simanowski	—	—	———	Carcinoma	Partial extirpation	Living a year after
27.	Skliffkowski ...	M.	47	1882	Carcinoma (?)	Partial extirpation	Recurrence three months after
28.	Rushton Parker ...	M.	39	30 April, 1887	Epithelioma	Unilateral extirpation	Death August 30, 1887

1 Morell Mackenzie's work. Table of Cancer.
2 Letter from Dr. Reyher to Dr. Foulis.
3 *Pratique Médicale*, November 22, 1887.
4 *Verhandlg. des XIII. Chir. Congresses*, S. 90.
5 *Archiv. of Laryngology*, April, 1883, S. 130.
6 *Pratique Médicale*, November 22, 1887.
7 *Ibid.*
8 *Ibid.*
9 *Ibid.*
10 *Ibid.*
11 *Ibid.*
12 Baratoux' Table. *Progrès Médicale*, 1886.
13 *Prat. Méd.*, November 22, 1887.
14 Baratoux' Table. *Progrès Médicale*, 1886.
15 *Pratique Médicale*, November 22, 1887.
16 *Ibid.*
17 *Ibid.*
18 Schwartz's Tables.
19 *Pratique Médicale.*
20 *Ibid.*
21 *Ibid.*
22 *Ibid.*
23 *Pratique Médicale*, November 22, 1887.
24 *Ibid.*
25 *Ibid.*
26 *Ibid.*
27 *Cent. für Chir.*, 1882, S. 421. *Wratsch.*, 1882, S. 14.
28 *Liverpool Med. Chir. Journal*, 1887.

Unilateral or Partial Excision.—II. For Sarcoma.

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. Kuster	M.	50	1881	Sarcoma	Unilateral extirpation	Alive in April, 1884
2. Gerster	M.	57	27 April, 1885	Sarcoma	Partial extirpation	Alive in February, 1886

1 *Verhandl. des XIII. Chir.-Congress*, S. 16.

2 *Pratique Médicale*, November 22, 1887.

III. For Other Conditions.

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. Heine	M.	36	18 Dec., 1874	Ossifying Perichondritis	Half the thyroid cartilage	Death 2 Nov. 1875 of cheesy peribronchitis and pneumonia
2. Foulis	M.	59	29 Jan., 1878	Stenosis	Part of cricoid cartilage	Death two months after
3. Foulis	M.	60	30 May, 1878	Stenosis (Diabetic)	Part of cricoid cartilage	Death two and a half months after
4. Yeo and Lister			March, 1878	Papilloma	Ablation of vocal cords	Cure
5. V. Bruns	M.	20	1 April, 1880	Stenosis (Typhoid)	Partial extirpation	Cured six weeks after
6. Caselli	M.	27	9 Nov. 1880	Enchondroma	Part of thyroid excised	Death two days after
7. Winiwarter	M.	—	18 Dec., 1883	Perichondritis	Right half of larynx preserving mucous membrane	Cured. Alive ten months after operation
8. Hahn	M.	22	23 April, 1884	Specific Stenosis	Half thyroid and cri. cartilages	Cure
9. Hahn	F.	40	26 Jan., 1885	Stenosis	Resection of cri. cart.	Cure, but a canula had later on to be inserted
10. Boecker	M.	62	April. 1885	Enchondroma	Extirpation of cricoid	Alive in October, 1886

1 *Chirurg. Congress*, 1 75. *Ibid.* S[illegible].
2 Case Book, Glasgow Training Home for Nurses.
3 *Ibid.*
4 Baratoux Table. *Prog. Méd.*, 1[illegible].
5 *Ibid.*
6 *Pratique Méd.*, November 22, 1887.
8 Hahn's Table in *Sammlung Klin. Vorträge*.
9 Baratoux' Table. *Prog. Méd.*, 1886.

ADDENDUM.

To the Table of Total Extirpations the following must be added :—

Operator.	Sex.	Age.	Date of Operation.	Nature of Disease.	Nature of Operation.	Subsequent History.
1. Agnew	M.	58	1886	Sarcoma	Total ablation, with resection of pharynx and œsophagus	Death four days after from suffocation
2. Morris	M.	59	1885	Epithelioma	Total ablation	Death four days after from collapse
3. Hahn	M.	68	1880	Cancroid	Total ablation, leaving the right half of the thyroid	There was no recurrence eleven months after. Patient said to be living in 1886

From the tables it is seen that out of twenty-nine cases of unilateral extirpation performed for carcinoma, four may be said to have died from the effects of the operation ; and in seven, recurrence is noted. Ten were reported living at the end of a year after operation. The results, so far as they go, are much better in sarcoma, but it must also be remembered that sarcoma of the larynx has been cured by endo-laryngeal methods just as carcinoma has. About 35 per cent. may be taken as the average percentage of successes, and the operation, therefore, shows results at least three times as favourable as that of total ablation, and may in the future show still better average. Allowing for the fallacious nature of statistics, and for the fact that it has not been possible to trace some of these cases, and for possible error in others, the general deductions from tables such as these must be decidedly adverse to the maintenance of total ablation as a practical surgical procedure, but will direct attention to the perfection of the methods of operating by, and knowledge of the indications for the operation of, partial excision of the larynx in malignant disease. The records of cases cured by endo-laryngeal procedures will also cause us to hesitate before advising severe measures, especially in cases where diagnosis admits of any doubt.

Hahn allowed a mortality percentage of 44 per cent. for total, as compared with 13·7 per cent. for partial, extirpation. It is not possible within the limits of this short article to analyse Hahn's important essay on extirpation of the larynx, but it should be read by all to whom the subject is of interest. A table of results of the operation of partial extirpation is given on preceding pages. While it is impossible as yet to draw any exact conclusions with regard to the operation, it is evident that so far as regards recurrence of this disease, it is not more frequent after partial than after total extirpation, and while after the former operation some (and in many cases a very good) voice is preserved to the patient, the general condition is one of comfort, compared with that of the individual who has submitted to total ablation of the larynx. While we have statistics enough to show the terrible nature of this latter operation, and the appalling uniformity of results, partial extirpation stands in much more favourable light, and though the operation is young compared with that of total ablation, it has so far given results which render it much more acceptable as a surgical procedure. Many surgeons, indeed, consider total ablation no longer a justifiable operation. Partial extirpation, on the contrary, is an operation the practice of which promises in the future much success, but even this should not be undertaken unless it is proved to be no longer possible to eradicate the disease by endo-laryngeal methods. That this, however, is possible has been clinically proved.

R. Norris Wolfenden.

NEW INSTRUMENTS AND THERAPEUTICS.

MAW, SON, & THOMPSON (London).—**New Forceps for Dilatation of Jaw.** *British Medical Journal, October* 8, 1887.

A DESCRIPTION, with illustration, of an instrument which will probably be of use to the surgeon who has no assistant at hand.

Hunter Mackenzie.

JONES, H. MACNAUGHTON (London).—**Antiseptic Cigarettes.** *British Med. Journ., September* 3, 1887.

OF these four varieties are recommended by the author: 1. Containing eucalyptus and iodoform disguised with vanillin. 2. Eucalyptus with iodo-salicylic acid. 3. Coltsfoot with eucalyptus and iodoform disguised with vanillin. 4. Tobacco, eucalyptus, and iodoform disguised with

coffee. Each cigarette contains one grain of the active ingredient. They are used for fumigation of the naso-pharynx. **Hunter Mackenzie.**

WOLTERING (Münster).—**Iodol as a Substitute for Iodoform.** *Monatsschr. für Ohrenheilk., etc.* 1887.

THE author has substituted iodol for iodoform in diseases of the larynx and nose, with good results. **Michael.**

SHOEMAKER, JOHN V. (Philadelphia).—**Collinsonia Canadensis.** *British Medical Journal, October* 1, 1887.

THIS is said to be among the most valuable of indigenous American medicinal plants. Amongst other uses it is recommended by the author as being palliative, if not curative, in whooping-cough ; it may safely be given in that affection without the dread of disordering the stomach. It may also be given with confidence in nervous cough, and the irritative cough of pharyngeal catarrh. Doses : powdered root, 10 to 60 grains ; tincture, 20 to 120 drops ; fluid extract, 15 to 60 drops ; infusion, 1 to 4 ounces. The physiological action has not yet been fully studied.

Hunter Mackenzie.

CARTWRIGHT-REED, S. (South Africa).—**Climate as a Therapeutic Agent in Phthisis.** *Lancet, September* 17, 1887.

THE author thus concludes a letter to the editor :—" The climate of South Africa generally benefits phthisical cases on first arrival, and here and there are some good examples of permanent benefit ; but, to secure all the benefit, you must travel, as a rule avoiding towns and villages. Travelling is very enjoyable over African plains, and not expensive." The author does not appear to entertain a high opinion of South Africa as a health resort for consumptives. **Hunter Mackenzie.**

SAVILL, T. D. (London).—**Remarks on Algiers and its Climate.** *Lancet, September* 24, 1887.

IN an interesting article the author remarks that the class of diseases for which Algiers is most suited is undoubtedly lung affections, especially phthisis. He quotes the following conclusions of Dr. Feuillet :—" 1. That phthisis originating in Algiers is rare. 2. That the disease, especially when imported, is cured in its early stages, without medical intervention, by the sole action of the climate : and even if it be a little more advanced, it is still cured or ameliorated by the same means. 3. The chances of abolishing hereditary tuberculosis are almost certain when the children are placed under such favourable conditions from infancy upwards." The article contains many meteorological details of interest.

Hunter Mackenzie.

ILLINGWORTH, C. R. (Clayton-le-Moors).—**The Biniodide Treatment of Scarlet Fever.** *British Med. Journ., September* 3, 1887.

THE author makes some remarks upon the local effects of the biniodide of mercury solution in some severe cases of scarlatina anginosa. He describes it as arresting the inflammatory and ulcerative action in a very

short time. He also injected it with benefit into the nose in some cases in which the disease had extended behind the soft palate. He thinks the same application would prove of service in diphtheria also. Formula: To 2 oz. of bichloride solution carefully add a few drops of a 1 in 4 solution of the iodide of sodium or potassium, shaking the mixture after each drop until a cloudy-red precipitate resulted. Add half-an-ounce of glycerine for suspension purposes. Apply twice daily with a straight brush (uncertainty as to the amount swallowed is stated by some to be an objection to this method of treating the scarlatinal sore-throat).

Hunter Mackenzie.

ILLINGWORTH, C. R. (Clayton-le-Moors).—**The Treatment of Scarlet Fever.** *British Medical Journal, September* 17, 1887.

THE writer recommends the biniodide of mercury not only as an effective means of combating the disease itself, but also as a prophylactic agent. Formula for internal use: 2 to 3 drachms of the solution of the bichloride of mercury; 10 to 15 grains of the iodide of potassium; ½ drachm of the citrate of iron and ammonia; ½ oz. of syrup; 1½ oz. of water. One teaspoonful every two hours for a child of from two to six years. Follow with iron and chlorate of potash after the biniodide mixture has been taken for eight to ten days, and if the temperature be normal. The author regards the throat as a far more potent source of infection than the desquamating cuticle. **Hunter Mackenzie.**

LANCET, Editor of (London).—**Treatment of Scarlet Fever.** *Lancet, September* 3, 1887.

IN this editorial note, attention is directed to the nature of the epidemic current at the period of writing, with special reference to its mildness, and the great attention given to the throat, which seems to suffer in a marked degree, the glandular swelling being correspondingly marked. Hence it will be found that gargles of all kinds, and especially those of an antiseptic nature, are freely used, together with compresses of heat and moisture applied to the neck. The editor remarks upon the importance of keeping the nostrils and nasal passages sweet and clean. For the relief of the thirst and sensation of dryness, nothing, it is stated, is more effective than ice and a little raspberry vinegar. Expectant treatment seems the rule in this disease. **Hunter Mackenzie.**

LANCET, Editor of (London).—**Influence of Temperature on Mortality Rates.** *Lancet, September* 3, 1887.

Scarlet Fever.—Minimum mortality from January to May; maximum in October and November. The conditions affecting its prevalence are evidently not limited to climatic conditions alone, but are more especially those which have led to the accumulation of susceptible persons in a community.

Diphtheria.—Differs from scarlet fever in the particular that it does not appear to protect the infected individual against subsequent attacks. It is also liable to periodic prevalence, and attains its maximum influence a

little later than scarlet fever, though its distribution during the year is more equal than the latter disease.

Measles and Whooping-cough.—The lowness of temperature of the winter months undoubtedly influences the mortality from these diseases, but their prevalence is also seasonal, and their mortality is actually highest during May and June. **Hunter Mackenzie.**

HOLLOWAY, GEORGE.—Whooping-Cough treated by Nasal Insufflations. *British Medical Journal, October* 15, 1887.

IN this article the author gives a brief account of twenty-four cases of whooping-cough treated with insufflations of boric acid. The patient is confined to one room for a week or ten days, and each nostril is insufflated every three hours during the day, and once during the night, with from two to three grains of finely-powdered boric acid. No difference is made in the diet, unless some special circumstance calls for it. At the end of ten days the child is allowed to go out in favourable weather. The results as described by the author appear very favourable.

For purposes of insufflation the author has devised a simple and cheap instrument, which is made by Messrs. Mappin, Birmingham.

Hunter Mackenzie.

LOWE, JOHN (London).—**Pure Benzol in Whooping-Cough.** *British Medical Journal. October* 15. 1887.

THIS article refers chiefly to the mode of administration. "The dose which I have usually found sufficient is from three to five minims, but a smaller quantity produces a decided effect. For a child of four or five years of age, two minims every two hours will suffice. Formula: ℞ Benzol pur., ♏xxxij. ; Glycerini pur., ℥jss. ; ol. menth. pip., ♏x. ; syr. mori., ℥ss ; Misce ; ℥j., 2dâ quâque horâ sumenda. The best time for beginning its use is after the acute stage is past. The most notable points in which its beneficial action is displayed are the diminished expectoration, and the decrease in the spasmodic nature of the cough."

Hunter Mackenzie.

LYNCH, J. ROCHE (London).—**Benzol in Whooping-cough.** *British Medical Journal, October* 29, 1887.

THE author endorses the favourable opinions entertained by others regarding this remedy. He has treated over 100 cases by benzol, and has lost one case only, a baby twenty-four days old. He administers it with mucilage and compound tincture of chloroform in from two to ten minim doses. **Hunter Mackenzie.**

KRÜNKE (Saales).—**Method of Application of Cocaine in Whooping-Cough.** *Deutsche Medicinal Zeit.*, 1887, No. 86.

A RECOMMENDATION of the internal use of this drug. **Michael.**

DIPHTHERIA.

JOHANNSEN (Liban).—**Prophylactic against Diphtheria.** *Petersburg Med. Wochenschr.*, 1887, No. 37.

GARGLING with permanganate of potash. Michael.

MERCIER.—Diphtheritic Angina: its Cure by Chloral. *Besançon*, 1887.

THE success of the treatment does not depend entirely on the employment of chloral, but principally on the way it is administered, viz., in small doses every half-hour, so as to cause the part affected to be constantly impregnated with it. An emetic is administered first, and syrup of chloral then given in spoonfuls, up to two, three, or five grammes, according to the age of the children.

The chloral separates the false membranes in a very short time, and has been the means of curing fifteen cases out of a hundred. Joal.

SNOW, HERBERT L. (Bayswater).—**Sulphurous Acid in Diphtheria.** *British Medical Journal, October* 8, 1887.

THIS remedy causes a rapid disappearance of the exudation, with corresponding improvement in the patient's general condition. Dose, &c.: in severe cases a drachm should be given to an adult every half hour; in ordinary cases every two hours. The only drawback is the choky sensation produced by the vapour. A large quantity of syrup ought to be given with the acid—say two or three ounces in an eight-ounce mixture. For young children it ought to be given in milk. Chlorate of potash may be combined with it to promote healing of the ulcers. The author appears to have great belief in this remedy. Hunter Mackenzie.

ILLINGWORTH, C. R. (Clayton-le-Moors).—**The Biniodide of Mercury in Diphtheria.** *British Medical Journal, October* 22, 1887.

THE author recommends both the local and the internal use of the remedy. When the throat is clear of exudation he gives iron and chlorate of potash. If the vital powers be low, he recommends the biniodide of mercury, with a slight excess of iodide of potassium or of sodium, every two hours, alternating with a dose of iron every two hours. Hunter Mackenzie.

MAIN, ROBERT (East Ilsley).—**Biniodide of Mercury in Diphtheria.** *British Medical Journal, October* 15, 1887.

A BRIEF note descriptive of two cases successfully treated with a gargle of corrosive sublimate (1 in 4,000) and the internal administration of iodide of potassium. (As the writer states he also treated the patients with iron and chlorate of potassium, the evidence here adduced in favour of the biniodide of mercury is not quite conclusive.)

Hunter Mackenzie.

MOLONY, FITZ-JAMES (Porlock, Somerset).—**Arsenic in Diphtheria.** *British Medical Journal, October* 29, 1887.

ARSENIC is recommended, after the removal of the diphtheritic membrane

as a local application on account of its antiseptic properties. The liquor arsenicalis may be thus used every three or four hours.

Hunter Mackenzie.

ROESE (Hamburg).—**Turpentine in the Treatment of Diphtheria.** *Therap. Monatschr., October*, 1887.

SIXTY cases thus treated showed good results. **Michael.**

SMITH, E. STANLEY (London).—**Diphtheria.** *British Medical Journal, October* 22, 1887.

AN enumeration of the various local and general remedies which the author has found of service in this disease, and which, according to the author's own statement, are neither new nor original.

Hunter Mackenzie.

CASADESUS, ROQUER. — Diphtheritic Pharyngo-Laryngitis; Tracheotomy; Cure. *Revista de Laringologia, Otologia y Rinologia, October*, 1887.

RELATION of a case in which hydrochlorate of pilocarpine, essential oil of turpentine, syrup of ipecacuanha, vapours of eucalyptus, and restorative broths were used, notwithstanding which the asphyxiative period of croup appeared, and it became necessary to perform tracheotomy. General medication was then continued, lemon juice was locally used, and the patient cured, although a small broncho-pneumonic focus appeared. The author finishes his observation with a few remarks upon the use of pilocarpine, and upon the performance of tracheotomy in diphtheria. **Sota y Lastra.**

BARRET, A. E. (London).—**Diphtheria Circumscripta.** *British Medical Journal, October* 15, 1887.

THE writer remarks upon the similarity between the herpetic form of exudative pharyngitis and diphtheria; the former is characterized by greater pain, and is less fatal than the latter. **Hunter Mackenzie.**

FRASER, G. R. (Wark-on-Tyne).—**Diphtheria Circumscripta, or Sandringham Sore Throat.** *British Medical Journal, October* 1, 1887.

A SHORT note, with descriptive cases of several of these complaints. The author considers it as being probably closely related to diphtheria, but without the local exudation of the latter; laryngeal symptoms are absent, and the danger to life is slight. All the cases recovered under alteratives and saline purgatives, and subsequently of tonics. **Hunter Mackenzie.**

ATKINSON, F. P. (Surbiton).—**The Cause or Causes of Diphtheria.** *British Medical Journal, September* 10, 1887.

IN a brief letter to the Editor, the author expresses his opinion that "it (diphtheria) often arises in country districts from defective sanitary arrangements, then gets carried into towns, and there spreads right and left by actual contact or infection." **Hunter Mackenzie.**

NOSE AND NASO-PHARYNX.

ROTH (Wien).—**The Diseases of the Mucous Membrane of the Nose, their Relation to the Common Organisms and their Treatment.** *Centralblatt für Therapie*, 1887, Nos. 10, 11.

A REVIEW of the subject. Michael.

REIMANN.—**On Micro-organisms in Nasal Secretions. Inaugural Dissertation.** *Würzberg*, 1887.

THE author found bacilli and cocci in the normal nasal secretions; he also found a bacillus in the secretions of ozæna, but never the pneumonia coccus described by Thost. Michael.

RICHARDSON, J. B. (Torquay).—**Paroxysmal Sneezing.** *British Medical Journal, October* 15, 1887.

IN reply to a note of inquiry, the following treatment is recommended. A lotion of one part of hydrochlorate of cocaine, one of carbolic acid, and one of essence of camphor to two drachms of water to be syringed up the nostrils each morning. Internally, iodide of potassium and arsenic. Dr. Daniel Bradley also recommends arsenic, especially in combination with bicarbonate of potass. He thinks the condition is due to a gouty condition of the patient. Hunter Mackenzie.

GRAHAM, BALFOUR (Leven, N.B.): **HAILES, CLEMENTS** (Clifton); **WILLIAMS, D. M.** (Liverpool).—**Paroxysmal Sneezing.** *British Medical Journal, October* 22, 1887.

SHORT notes regarding the treatment of this complaint. The remedies recommended are: arsenic, Ferrier's snuff (Pulv. Bismuthi Co.), camphor and the local application of "thylum" or "hippacea,"—this latter being the produce of an Indian umbelliferous plant. Hunter Mackenzie.

WALKER, T. OSBORNE (Crick).—**A Ready Method of Removing Foreign Bodies from the Anterior Nares.** *Lancet, September* 17, 1887.

THE author directs attention to the following points as of importance:—"The close confinement of the hands, arms, and legs by a shawl, blanket, or apron; a good light; a reliable person to securely hold the child; the position of the operator behind the patient; depressing well the apex of the nose to obtain a good view of the object; and lastly, getting the concave face of the spoon of a director fairly behind the body before making the forward lever movement." Hunter Mackenzie.

ANONYMOUS.—**A Caterpillar in the Nose.** *Lancet, September* 10, 1887.

BRIEF note of a case. Hunter Mackenzie.

CAMPBELL, C. M. (London).—**Case of Plastic Operation for Destruction of the Nose by Syphilis.** *Lancet, September* 17, 1887.

THE title indicates the nature of the case. **Hunter Mackenzie.**

NATIER.—Two Cases of Deviation of the Nasal Septum. *Journ. de Méd. de Bordeaux, August,* 1887.

THE author presented to the Anatomical Society of Bordeaux, two children with this deformity. The first, seven years old, since the commencement of his illness suffered from very frequent spasms of the right eye. The second case was one of congenital deviation, with flow of tears.

Joal.

ALVIN.—Irrigation with Hot Water in Severe Epistaxis. *Loire Médicale, August* 15, 1887.

1. Irrigation with very hot water is a very powerful method of arresting epistaxis, especially when severe.

2. It possesses no danger, is accepted by the patient without repugnance, and gives rise to no pain.

3. The patient should be kept under watch for ten hours, having hot water and an irrigator at hand.

This practice has been very successful in Alvin's hands, and he was able, at Mont Dore, to arrest a grave epistaxis by this means, which had lasted several days, and for which Dr. Percepied and the abstractor had in vain employed astringents, alum, tannin, antipyrin, perchloride of iron, posterior tampons, mustard pediluvia, ice, injections of ergotine, &c. Nothing had succeeded, the blood continuously flowing and exuding through the puncta lachrymalis. Dr. Alvin arrested the hæmorrhage by a nasal irrigator and water at 70° C., thus rendering a signal service to the patient and ourselves, for which we are happy to congratulate him.

Joal.

STÖRCH.—On Rhinoscleroma. *Präger. Zeit.* 1887, p. 257.

BACTERIOLOGICAL essay. **Michael.**

MOUTH, TONSILS, PHARYNX, &c.

ZIEM.—Pathology of the Lips. *Allg. Med. Centralztg.*, 86. Nos. 68, 69.

SCROFULOUS conditions of the lips are caused by disturbance of circulation through diseases of the nose, pharynx, and teeth ; with the cure of these conditions the affection disappears. **Michael.**

SCHRAKAMP (Stuttgart).—**Differential Diagnosis of Diseases of the Mouth.** *Deutsche Med. Wochenschr.*, 1887, No. 41.

TWO cases of diphtheria of the mouth, with remarks. **Michael.**

MONOD.—Congenital Adhesion of the Arch of the Palate to the Posterior Wall of the Pharynx. *Journal de Méd. de Bordeaux, July* 24, 1887.

THE patient was a man of seventy-three, in good health, without any specific history or sign of ulceration of the pharynx. The lateral parts of the palatine arch, divided in the mid-line, were joined to the posterior wall of the pharynx, the anchylosis appearing to exist principally at the level of the posterior pillars, which are no longer recognizable. There is no trace of tonsils. In the interval of the two adherent extremities of the arch, a large oval aperture exists, six centimetres from before backwards, and through which is seen the mucosa of the post-nasal region. Cases of this kind, of congenital origin, are very rare. **Joal.**

DURET.—On Palatine Angioma. *Journ. des Sciences Méd. de Lille, July*, 1887.

THE angioma was produced accidentally by an explosive cigar, which determined a rupture or vascular irritation, indistinguishable from a venous erectile tumour. The patient was treated with an injection of ten drops of Piazza's liquor—

Perchloride of iron	...	...	25 grammes.
Chloride of sodium	...	...	15 „
Water ...	...	...	60 „

and a complete cure resulted. **Joal.**

LUBLINSKI.—Concretions in the Tonsils. *Monatschr. für Ohrenheilk.*, 1887, No. 10.

THE concretion was two and a half cent. long, three-seventh cent. broad, and half a cent. thick, and consisted of carbonate and phosphate of lime. **Michael.**

LUBLINSKI.—Polypus of the Tonsil. *Monatschr. für Ohrenheilk.*, 1887, No. 10.

A POLYPUS was observed in one of the author's patients, three and one-fifth cent. long, and was removed with scissors. **Michael.**

FERRE.—On a Case of Pharyngo-mycosis. *Journ. de Méd. de Bordeaux, July*, 1887.

THE author has examined the white product taken from the tonsils of a patient in the clinique of Dr. Moure. He concludes, along with Baginsky, Gumbiner, Bayer, Klebs, Hering, &c., that the basis of pharyngo-mycosis is leptothrix buccalis.

WROBLEWSKI.—Pharyngeal Tuberculosis. *Gazeta Lekarska*, No. 43–46, 1887.

THIS is a monograph based upon the works of different authors, and followed by the history of sixteen cases observed by the author in the hospital of St. Roch, in Warsaw, and in his private practice. In only one of his cases was the disease primary; in all the others it was secondary to

phthisis of the lungs and larynx. The affection most commonly occupied the uvula and the arch of the palate, more rarely the posterior pharngeal wall. It was always accompanied with cervical adenopathy, and appeared upon neighbouring parts, first, as small buds of grey or red colour, which speedily ulcerated. The secretion always contained Koch's bacilli. The course of the disease was almost always rapid, and ended fatally. Even when the ulcers were cicatrized under treatment, the general state was never ameliorated. The author prefers for local treatment, submucous injections of cocaine (10 to 20 per cent.), local disinfection by carbolic acid (2 to 5 per cent.), or corrosive sublimate (1-1,000) and curetting, followed by energetic frictions of lactic acid.

Const. Karwowski.

WILD, R. B. (Manchester).—**The Action of Quinine and Allied Substances on Involuntary Muscular Tissue (Œsophagus of the Frog).** *British Med. Journ., September* 3, 1887.

As the result of a series of careful experiments and observations, the author found, amongst others, that quinine caused contraction of the muscular fibres of the œsophagus. The œsophagus, after the prolonged action of quinine, was smaller and distinctly harder, and the lumen almost obliterated. The article is well worthy of perusal.

Hunter Mackenzie.

BRIDGMAN, HENRY E. (Burton-on-Trent).—**Lodgment of a Tooth-plate in the Gullet for Fifteen Months.** *Lancet, September* 24, 1887.

In this case one point of considerable interest is, that immediately after the lodgment of the foreign body in the gullet, probangs were passed into the stomach without meeting with any obstruction in the gullet. Some dyspnœa and dysphagia which ensued soon afterwards, disappeared for a few weeks, and then recurred, accompanied by a hard frequent cough, and the copious expectoration of a tenacious mucus, tinged with blood. The plate was finally expelled during a violent fit of retching.

Hunter Mackenzie.

JOZEFCZYK.—**Cancer of the Œsophagus.** *Przeglond Krakowski*, No. 29, 1887.

A man of fifty-nine consulted the author for difficulty of deglutition of solids. A stenosis of the œsophagus having been determined, the author proceeded to dilate with the finest of Trousseau's sounds. After the introduction of a No. 3 sound, the patient felt an excruciating pain, which lasted for twelve hours, at the end of which time he died. Another physician, called in at the last moment, emitted the opinion that the unfortunate accident had been provoked by the want of ability of the operator, and made such a representation to the legal authorities. At the judicial autopsy a stenosis and a perforation of the œsophagus were found, with pus and liquid extrusion into the mediastinum and pleural cavity. This was produced by a cancer in process of softening.

The operator was acquitted of all blame in causing the death of the patient.

[What is to be thought of the practitioner who would prefer such a charge against a *confrère?* We hope the Polish law is not without means of reaching the offender.] Const. Karwowski.

LARYNX.

LANDGRAF.—On Affections of the Larynx in Croupous Pneumonia. *Charité Annalen.*, 1887, *p.* 277.

In eighty cases of pneumonia seen by the author two cases presented ulcerations on the processus vocales. Of these one is since dead, the other was cured with cicatrization. Michael.

LEWIN, G. (Berlin).—**Contribution to the Knowledge of Laryngeal Perichondritis, with special reference to Syphilis.** *Charité Annalen*, XII., p. 728, 1887.

Communication of a case of specific perichondritis, the subject of which died suddenly. The autopsy showed that the whole cricoid cartilage was transformed into a perichondritic abscess. The cartilage which is most frequently affected is the arytenoid, next the cricoid, and lastly the thyroid. The progress and symptomatology of these cases vary according as the disease is primary or secondary. Syphilitic perichondritis is characterized by the absence of pain. The process may be progressive or retrogressive. In specific cases running their natural course without treatment gummatous perichondritis may be metamorphosed into an abscess which will speedily open. The sequestrated cartilage is then coughed out. In the secondary form the cure is often only relative with production of stenosing cicatrices and ankylosis of the crico-arytenoid joint. Therapeusis must be anti-syphilitic, and in case of great stenosis tracheotomy must be performed. Michael.

CHARAZAC. Sulphur in Laryngeal Tuberculosis. *Soc. Méd. de Toulouse, September*, 1887.

Dr. Moure, in a communication made to the Copenhagen Congress, had the distinction of being the first to protest against the employment of sulphur in laryngeal phthisis. The author also would warn against the tendency of so many physicians to send patients indiscriminately to Cauterets, Eaux Bonnes, Luchon, &c., afflicted with throat complaints of the most various kind. When sulphurous waters are administered in laryngeal tuberculosis congestion is observed to replace anæmia, so that while the mucosa was previously pale, it becomes difficult to distinguish the true cords from the ventricular bands, the whole has such a rosy tint. The author publishes the cases of seven patients whose condition has been aggravated by sulphur waters. In one, infiltration, ulceration, and considerable loss of substance of the epiglottis resulted. In another, after a year at Cauterets, the epiglottis became œdematous and exhibited numerous ulcerations; the arytenoid

region and ventricular bands were very tumefied. One patient had to undergo tracheotomy at the thermal station in consequence of œdema glottidis. In the seven patients acute symptoms developed in the larynx. Charazac concludes, to give sulphur waters in laryngeal tuberculosis is to furnish a most favourable soil for the development of germs, and cites Pidoux, who remarks as follows—"Sulphur waters are always fruitless or harmful in true laryngeal phthisis." **Joal.**

PRZEBORSKI.—Methods of Treatment of Laryngeal Phthisis. *Gazeta Lekarska*, No. 37—39, 1887.

AFTER having described the methods of Krause, Jelinek, M. Schmidt, Gottstein, Massei, Hering, and others, the author gives preference to Hering's method of treatment, and describes five cases in which lactic acid, scarification, curetting, &c., have given excellent results as regards the cure of phthisical ulcers. **Const. Karwowski.**

WROBLEWSKI.—Large Papilloma of the Larynx; Extirpation by the Curette; Cure. *Klinika*, No. 22, 1887.

THE author believes himself to be the first to have employed the curette for the extirpation of a large papilloma, which, springing from the inferior third of the epiglottis, almost completely occluded the opening of the larynx, leaving only a space admitting a sound of very small calibre. The tumour was completely immoveable. The patient, who breathed with great difficulty, presented external signs of chronic perichondritis, with accumulation of pus round the thyroid cartilage. The patient also presented a mass of polypi in the left nares. There had never been syphilis. The patient had suffered for six years. Treatment was commenced by performing laryngotomy through the crico-thyroid ligament, leaving the cricoid cartilage intact. During the operation, and for some days after, the patient passed through the canula a large amount of pus. Six days after the first operation, the author commenced to remove portions of the papilloma by means of Hering's sharp curette, the whole being completed on the sixth sitting. The canula was removed on the twentieth day, and six days later the patient left the hospital cured, presenting only a smooth cicatrix on the epiglottis, not impeding the movements of this organ in the least. Anatomico-pathological examination of the tumour, made by a specialist, demonstrated nothing suspicious, and proved it to be composed chiefly of granulation tissue. The author believes that the origin of the excrescence was simple inflammatory perichondritis, with partial necrosis and elimination of the necrotic parts of the thyroid cartilage. **Const. Karwowski.**

MACDONALD, GREVILLE (London).**—Two Cases of Idiopathic Intra-Laryngeal Abscess.** *Lancet*, *September* 24, 1887.

IN the first case, a woman aged forty, and probably syphilitic, an enormous swelling was situated on the right ventricular band, from which, after puncturing, creamy pus exuded. The author conjectures that the abscess may probably have been due to an acute inflammatory attack supervening upon a chronic laryngitis. In the second case, a woman

aged thirty-eight, there was found projecting inwards from the right ary-epiglottic fold, and resting apparently on the ventricular band, a smooth, dull red, somewhat translucent swelling. Pus was liberated as in the first case. Both rapidly healed after evacuation of their contents.

Hunter Mackenzie.

DEFONTAINE.—Inter-crico-thyroid Laryngectomy. *Pratique Médicale, October* 11, 1887.

THE author shares the opinion of Chauvel, Marchand, Gosselin, Gougenheim, &c., that this operation should not be practised in old people, children, or in cases of laryngeal disease leading to ossification of the cartilages. On the other hand, the operation is preferable to tracheotomy when extension of the head causes asphyxia, when there is only a little space between the cricoid and the sternal fourchette, when there is considerable vascularization of the neck, and when the trachea is deeply seated.

Joal.

ALFRED SOKOTOWSKI.—Syphilitic Stenosis of the Trachea and Bronchi. *Gazeta Lekarska*, No. 37, 38, 1887.

THIS condition is rare, and at the commencement is impossible to diagnose. At a later period, viz., that of stenosis, asphyxia is well characterized by inspiratory dyspnœa. It occurs oftenest in men, as a phenomenon of acquired syphilis, or in children, of hereditary origin. It is curable only in the earliest stages. Two cases have been observed by the author. One was a young man of nineteen, who had experienced cough for three years, and nocturnal attacks of dyspnœa for three months. In one of these attacks life was only saved by prompt tracheotomy. Two weeks after a severe dyspnœic attack carried the patient off. At the autopsy was found great stenosis of the trachea due to cicatrices, and to pressure on the recurrent laryngeal nerves by enormously hypertrophied lymphatic glands, and complete obstruction of the bronchi by mucus. The author believes that death was due to paralysis of the dilator muscles of the glottis, and stoppage of the bronchi by mucus. The second case was that of a man of fifty-six, in whom dyspnœa and asphyxiative attacks appeared twenty-two years after the syphilitic contagion. He had been tracheotomized during an attack, lived for five months, eventually dying of pneumonia. No autopsy was made, but as the patient presented during life characteristic deep ulcers and cicatrices on the body, exostosis of the tibia, and paralysis of the posterior crico-arytenoid muscles, the author based his diagnosis of syphilitic stenosis of the bronchi on the similarity of this case to the previously recorded one, and to other recorded observations.

Const. Karwowski.

BUTZ. Prophylactic Tamponnading of the Trachea. *St. Pet. Med. Wochenschr.*, 1887, No. 72.

TO prevent the entrance of blood into the lungs, and to simplify narcosis in operating on the mouth and pharynx, the author performs prophylactic tracheotomy. To the canula is fixed a communication with the chloroform mask, and the pharynx is tamponned with iodoform gauze.

Michaol.

HANOT.—Cervico-broncho-tracheal Adenopathy. Perforation of the Œsophagus and Trachea. Intestinal Septicæmia. Grey Pneumonia of the Lower Lobes of both Lungs. *Archives Générales de Médecine, September*, 1887.

AT the autopsy of the patient, twenty years old, it was found that at the level of the perforation, the trachea and œsophagus opened into a cavern formed out of suppurated ganglia, and full of sero-purulent liquid. An intractable diarrhœa and two pneumonic nuclei had developed from the passage of the putrid matters into the intestine and the pulmonary alveoli. **Joal.**

NECK, &c.

MORRIS, HENRY (London).—**Two Cases of Disease of the Thyroid—One Treated by Excision, the Other by Injection of Iodine; Recovery; Remarks.** *Lancet, September* 24, 1887.

BOTH were cases of simple hypertrophy of the gland. "The object in putting the case of thyroidectomy on record is because now, at the end of three years, the girl is in good health, and shows no sign whatever of any threatening of myxœdema." **Hunter Machenzie.**

OECHEL (Berlin).—**Cases of Strumectomy and Cachexia Strumipriva.** *Inaugural dissertat., Berlin*, 1887.

OF seven cases operated upon by Bardeleben, three are since dead, and four are cured, but in not one of these cases did any symptoms of cachexia follow. **Michael.**

OBOLINSKY (Krakau).—**Modern Surgery of Goître.** *Wiener Med. Presse*, Nos. 30, 31, 1887.

CASE of struma operated upon by ligature of all four thyroid arteries, with good result. **Michael.**

KÖHLER.—Communications from the Surgical Clinic of Professor Bardeleben. *Deutsche Zeitsch. für Chirurgie, Bd.* 26, *pp.* 1, 2.

REPORT of twenty-four extirpations of the thyroid gland; of these nine were partial and fifteen total extirpations; five of the latter are dead. The other ten are cured, and without any sign of cachexia strumipriva or myxœdema. **Michael.**

LUCY, REGINALD H. (Plymouth).—**Leucoderma associated with Graves's Disease.** *British Medical Journal, September* 17, 1887.

RECORD of a case in a female aged twenty-one years. The author remarks upon the unusual nature of this association.

Hunter Mackenzie.

WORNER, G. PORTER (London).—**Notes on a Case of Determined Suicide, involving points of Medico-Legal Interest.** *British Medical Journal, October* 1, 1887.

CASE of cut-throat, in which death ensued within ten hours. The following were the injuries to the throat:—A wound four inches long, two-thirds of which were to the left of the median line, dividing the trachea immediately below the cricoid, leaving the posterior third intact: the anterior borders of both sterno-mastoids were notched, the right more deeply. There were several incisions and scratches over both arms. The points emphasized by the author are the resistance offered after such mutilation and hæmorrhage, and the opinion expressed by another surgeon that the wounds could not have been self-inflicted. (The author witnessed the self-infliction of some of the wounds.)

Hunter Mackenzie.

AFANASSIEW (St. Petersburg).—**Etiology, and Clinical Bacteriology of Whooping-cough.** *St. Petersburg Med. Wochenschr.*, 1887, Nos. 39, 40, 41, 42.

VERY interesting and exact researches on this disease, leading to the following results:—In the sputa of patients with whooping-cough are found small and short bacteria differing from all pathogenic and non-pathogenic microbes by certain morphological and biological peculiarities. That these bacteria are pathological is proved by the production in dogs and rabbits of a disease similar to whooping-cough after injections of the materies morbi into the lungs. Bacteria are found to occur in the infected animals on the mucous membrane of the bronchi, trachea, and nose. They are also found in the bodies of patients who have died from whooping-cough. The author concludes that whooping-cough is of bacillary origin, and names the special organism, "bacillus tussis convulsivæ."

Michael.

ASTIER.—Suppuration of the Maxillary Sinus treated with Cauterizations of Silver Nitrate. *Rev. Générale de Clinique et de Thérapeutique, July*, 1887.

PERFORATION of the alveolar arch of the maxilla is the only rational method of treatment, for catheterism of the sinus, as proposed by Schiffers, is very difficult, and liquids thus injected do not find exit from the lower part of the sinus, thus badly fulfilling their antiseptic properties. Astier then relates a case in which he obtained a cure by penetration of the alveolar opening with a canulated sound, in the groove of which he had fused nitrate of silver, and touching the walls of the sinus in as great an extent as possible by the extremity of the sound. **Joal.**

MULLER.—Uterine Cough. *Thèse, Paris*, 1887.

THE author has studied this well-known reflex phenomenon. It occurs chiefly during pregnancy, in the physiological state. Malignant tumours rarely give rise to it, but it is met with in fibromata, metritis, and especially in uterine displacements. It is quite distinct from hysterical

cough as described by Sydenham and Lasegue, not having at all the same characters. The important diagnostic point is to be forewarned of the possibility of this cough, so as to remind us of the necessity of uterine examination if the cough is not justified by the presence of disease of any other organ; in other respects, it possesses no distinctive characters, and is difficult to differentiate from other symptomatic coughs, when there does not exist any other concomitant sign. The treatment should be directed to the uterine condition. **Joal.**

BARRON BARCLAY, J. (Bristol).—**Unusual Cause of Staining of the Skin by Nitrate of Silver.** *British Medical Journal, October* 22, 1887.

IN this case the swabbing of the throat with a solution of the silver salt by another practitioner had caused absorption of a sufficient quantity to tinge the skin. The writer suggests that this tends to bear out the modern theory that the tonsils have a good deal to do, as absorbent glands. **Hunter Mackenzie.**

BASTIAN, H. CHARLTON (London).—**On Different Kinds of Aphasia, with Special Reference to their Classification and Ultimate Pathology.** *British Medical Journal, October* 29, 1887, *et seq.*

A PAPER read in the Section of Medicine at the annual meeting of the British Medical Association, 1887. It is impossible within brief limits to make an abstract of this learned communication, which possesses some points of interest to the laryngologist, but is mainly of neurological importance. **Hunter Mackenzie.**

MILLIGAN, WILLIAM (South Tottenham).—**Fatal Poisoning by Nitric Acid.** *Lancet, September* 10, 1887.

ABOUT ½ oz. of the acid was taken for suicidal purposes. Amongst other symptoms were oozing of frothy mucus from the lips; lips and gums chalky white; yellow stain on the chin; tongue covered with pale yellowish coating. Death occurred in eighteen hours. **Hunter Mackenzie.**

HEDINGEN (Stuttgart).—**Report of the "Heilanstalt für Ohrenkränke in Stuttgart" for 1883—1885, and further Information upon the Progress of Aural Therapeutics for the Past Year.** *Würtembg. Med. Correspondenzblatt,* 1887, No. 35.

NEUROSES of the trigeminus occur, as: Trigeminal cough (Schadewald), anæsthesia, hyperæsthesia, and neuralgia. Neurosis of the olfactory nerve was seen in one case under the form of anosmia. Hypertrophy of the nasal conchæ, papillomatous degeneration of the mucous membrane with reflex asthma was seen in one case and cured by the galvano-cautery, chromic acid, and menthol tampons. The cure was interrupted by an epistaxis caused by the chromic acid. **Michael.**

ASSOCIATION AND CONGRESS MEETINGS.

Sixtieth Meeting of German Naturalists and Physicians, 1887.

SECTION OF LARYNGOLOGY.

First Meeting, September 20.

President, HERR HEINRICH; *Secretaries*, HERR FISCHENICH, HERR A. SCHNITZLER, HERR PROEBSTING.

A paper was read by HERING, of Warsaw, *On Curettement of Tubercular Ulcers of the Larynx and its Results; with Demonstrations.* The author exhibited some specimens (examined by Virchow) which showed the cicatrisation of tubercular ulcers as the effect of the author's plan of treatment. Of fifteen patients treated with lactic acid eleven were cured, eight having remained for more than a year without recurrence. As lactic acid alone gave no definite results he combined this treatment with curettement, or applied the latter alone. Curettement is indicated in tubercular tumours of the posterior walls, and for ulcers with thickened edges. Cocaine anæsthesia should first be obtained, and antisepsis ensured with iodoform emulsion. In twenty-seven cases out of thirty-five so treated, the results have been excellent. Hering also read a letter from Krause supporting this method of treatment.

A paper was read by SCHNITZLER, of Vienna, *On new Medicaments, and Methods of Treating Tuberculosis of the Larynx.* Various drugs had at different times been more or less successful, and the disease had even appeared to undergo cure, without any special treatment. The general treatment of the disease must be kept in view before everything. Phosphate of lime, as recommended by Kolischer, had latterly been employed by the author, but without any particular benefit.

CUBE (Mentone) remarked that, according to recent views on the pathology of the disease, it was (except in the case of acute miliary tuberculosis) primarily a local disease, and local surgical treatment as proposed by the speaker was therefore rational.

SCHMIDT (Frankfort o/M.) agreed with Schnitzler that general treatment must be kept in view. He was better pleased with lactic acid than with any other application, but since it often failed in infiltrations, was very glad to hear of any other suggestions.

GOTTSTEIN (Breslau) was also satisfied of the effects of lactic acid.

HERING remarked that in all cases, the diagnosis was confirmed by the detection of tubercle bacilli. Asepsis was obtained by brushing with iodoform emulsion and gargling a solution of lactic acid.

A paper was read by SCHNITZLER (Vienna) *On the Transformation of Benign Tumours of the Larynx into Malignant Tumours.*—The author related a case of epithelial carcinoma of the larynx, with medullary metastasis of the lymphatic glands and pleura. Diagnosis was confirmed by the autopsy. The patient had been operated upon by another laryngologist for papilloma, and subsequently cauterised, and came to the author with perichondritis. Schnitzler diagnosed carcinoma. He then spoke of the rarity of transformations. In many hundred cases of papilloma he had only met with them in three cases, and there is therefore no ground for condemning intra-laryngeal operations. He then dwelt upon the difficulties of diagnosis between malignant and benign growths and syphilis.

MORELLI (Pesth) related a case of papilloma which was extirpated by Navratil,

after tracheotomy and laryngo-fission, with the galvano-cautery. The patient was cured, and left the hospital without canula and without any recurrence, but subsequently an extensive carcinoma, was diagnosed. He had only seen this one case of the kind.

SEIFFERT (Wurzburg) agreed with Schnitzler that differential diagnosis was often difficult, and that cases of suspected carcinoma should first be treated by antisyphilitic measures before operation. He remembered a case published by Boehmer in which a papilloma had become transformed into a carcinoma.

HEYMANN (Berlin) related a case of transformation of a benign nasal polypus, which had been operated upon, into melanotic sarcoma. It was afterwards operated on with the galvano-cautery wire, and had not subsequently recurred.

GOTTSTEIN (Breslau) remarked that transformation could not be diagnosed only by the laryngoscopic appearances, since we cannot determine by this means if the mucous membrane has been invaded by the neoformation, which is regarded by Virchow as distinctive of malignancy.

SCHNITZLER related a case of transformation of a benign papilloma into carcinoma, and subsequently into medullary sarcoma.

A paper was read by ONODI (Pesth), entitled *Contribution to the Study of Innervation and Paralyses of the Larynx*. Researches have been conducted by the author upon the crico-thyroid muscle, and in a large proportion of cases he has traced a relation between this muscle and the superior laryngeal nerve. Anastomotic connections were sometimes found with the inferior laryngeal nerve. The ramus pharyngeus vagi makes exit with two roots of the vagus, and the upper sympathetic node, of which one communicates with the pharynx and the other with the superior laryngeal nerve. He proposes not to call this nerve, as Exner does, the laryngeus medius, but to give it another name. He has also found that the superior laryngeal nerve (as well as the inferior) innervates the arytenoideus transversus muscle. Five anastomoses have been found by him between the branches of the superior and inferior laryngeal nerves. By means of these communications diphtheritic paralyses can easily be propagated from one nerve to the other.

(*To be continued.*)

Ninth International Medical Congress.

SECTION IN LARYNGOLOGY.

Intubation of the Larynx in Chronic Stenosis. By Dr. JOSEPH O'DWYER.

THE value of intubation of the larynx in chronic stenosis would amply repay me for the time and expense consumed in developing it, even if it had proved a complete failure in the treatment of croup.

I here report five cases of chronic stricture of the glottis treated by intubation, three of them by myself, and two by other physicians :—

CASE I.—Mrs. V., aged forty. Contracted syphilis from her husband twelve years ago. Syphilitic laryngitis. Dyspnœa for two years, and severe dyspnœa for two months, growing worse. Immediate tracheotomy advised by a prominent laryngologist. The soft palate was adherent to the posterior wall of the pharynx on both sides, and a small ulcer still existed on the left side. A cicatricial band encircled the left half of the larynx and crossed to the right over the posterior portion of the chink, leaving only a very small breathing space between it and the right cord. The epiglottis was also deformed on its posterior surface by cicatricial contraction.

The larynx was intubated December 5, 1885, for the first time, the first period of treatment lasting eighteen days. The tube was inserted nine times, its size being gradually increased, and was retained in the larynx one hundred and seventy-three hours. The second period of treatment lasted twenty-seven days. The tube was introduced thirteen times, and retained in the larynx two hundred and four hours. This gave the patient ample breathing space, but as there still remains active disease in the larynx, it is necessary to reintroduce the tube for twelve to forty-eight hours every month or six weeks. She is on anti-syphilitic treatment, and I am teaching her to introduce the tube herself.

CASE II.—Louise M., aged thirty-five. Syphilitic laryngitis and paralysis of the abductors of the vocal cords. Laryngotomy was performed at Charity Hospital two years ago, and she had never been able to dispense with the tube since that time. The amount of air that passes through the larynx is so small that her efforts at conversation are unintelligible. The presence of the tube keeps up a very offensive bronchitis and tracheitis, and she is losing flesh and strength very rapidly. She has well-marked syphilitic lesions. In the mirror the vocal cords could be seen closely approximated, but normal in appearance. No adhesions were visible, and during all attempts at phonation or inspiration, the arytenoids remained motionless.

On April 29, 1886, an examination under ether showed complete occlusion of the larynx, which I overcame by rapid divulsion. On inserting a laryngeal tube, its lower end came out through the wound, and no means that I could devise would keep it in place. Therefore I was compelled to reinsert the tracheal canula until a longer tube (three inches) could be made.

May 8, 1886. Intubation was performed with the long tube. After the first day the tube caused but little irritation, and the patient drank, ate, and expectorated without difficulty.

May 20, 1886.—Patient was etherized, and a small portion of each of the vocal cords was removed to overcome the obstruction due to the paralysis of the abductors. From May 8 to June 29, 1886, the tube was inserted ten times and retained in the larynx forty-six days, its size being increased as rapidly as possible.

June 29, 1886.—The tracheal wound has entirely healed. The tube was removed from the larynx three days ago, and she breathes fairly well without it. It was considered advisable to insert a larger tube and allow it to remain in the larynx for one month. This was done, and the patient returned to Charity Hospital, wearing the tube. She eloped from the hospital, and I did not see her again until May 3, 1887. She had worn the tube continuously for ten months and four days. She was in excellent health, and the presence of the tube caused her so little inconvenience that it was with difficulty I persuaded her to allow me to remove it. The tube was black from coating of the sulphides, and closely dotted over with coarse granules of calcareous matter. An examination of the larynx showed masses of granulation tissue growing from the sides of the larynx above the ventricular bands, and later examinations showed that they were gradually decreasing in size. There was undoubted motion of the arytenoids during inspiration, but the vocal cords were not visible. There has been no return of the dyspnœa since the removal of the tube. She was last seen in the early part of August, 1887.

CASE III.—Mrs. L., aged forty. She contracted syphilis several years ago, and has suffered from a syphilitic laryngitis for about one month. She had albuminuria when I was called to see her—January 14, 1887. She had urgent dyspnœa, mostly due to sub-glottic œdema, and she was in imminent danger of suffocation. I inserted a tube in the larynx without the use of an anæsthetic, and she obtained immediate and complete relief. The first period of treatment lasted twenty-one

days ; the tube was inserted four times and was retained in the larynx twenty days. She swallowed with difficulty, and was fed at first by the rectum, and later by the stomach with a tube.

March 14, 1887, about six weeks after the last removal of the tube, I was called in great haste to see her, and found her deeply cyanosed. After some difficulty I inserted the tube, which gave complete relief. This time the obstruction was due to a gumma on the anterior surface of the left arytenoid, and involving a considerable part of the posterior region of the larynx, and overlapping the chink of the glottis. This period of treatment lasted fourteen days, the tube was inserted twice and retained in the larynx fourteen days. During this time she learned to swallow both liquids and solids very well. I have not seen the patient since, but have been recently informed that there is still some dyspnœa on exertion, and very little voice, both symptoms being probably due to remaining sub-glottic thickening; but I have no knowledge of the recent laryngoscopic appearances.

Case IV.—This patient was treated by Dr. J. J. Reid, at Charity Hospital, and briefly reported by him in the *Philadelphia Med. and Sur. Reporter*, May 14, 1887.

J. K., aged twenty-two. He had an attack of laryngitis four years ago, which steadily grew worse until he entered the hospital, May 1, 1886. There were considerable emaciation, hoarseness, cough, and dyspnœa at night. He gave no distinct history of syphilis, but there was necrosis of the hyoid bone, part of which had escaped by the mouth, leaving a discharging sinus on the inside. Ulceration existed around the base of the epiglottis, and involving the left side of the larynx to the arytenoids, both of which were much swollen and partially anchylosed. The dyspnœa increased until the question of surgical interference had to be considered. I saw the case with Dr. Reid, and thought that the presence of the tube would only aggravate the existing ulceration. On September 20, 1886, Dr. Reid intubated the larynx. This period of treatment lasted twenty-seven days ; the tube was inserted four times and retained in the larynx nineteen days twenty-one and a half hours. The tube was again inserted for twenty-four hours on December 15, 1886. The presence of the tube caused very little irritation, and the patient slept, and took nourishment well. He was seen in June, 1887, six months after the final removal of the tube, and there was no return of the dyspnœa.

Case V.—This case was operated on by Dr. Dillon Brown. The patient was a German, aged thirty-nine. For some time he had been subject to severe attacks of laryngitis accompanied by dyspnœa, which grew so severe that tracheotomy became necessary. This was done December 24, 1886. On laryngoscopic examination, a subglottic neoplasm was discovered. It was very vascular, and on scraping it out with a curette, a piece of lucifer match three-quarters of an inch long was found imbedded in its centre. The canula was removed three days later, and the wound allowed to heal. However, the dyspnœa returned, and on January 18, 1887, the trachea was reopened, while the patient was pulseless and almost asphyxiated. Nine days later the thyroid cartilage was laid open in order to remove the cause of the obstruction, but in spite of this, he was unable to dispense with his tracheal canula.

On March 25, 1887, Dr. Brown inserted a tube in the larynx, the patient being under the influence of an anæsthetic. He was of a nervous, irritable temperament, and the tube gave rise to excessive irritation, which called for the frequent use of opiates.

The tube was removed in a week, and there was no return of the dyspnœa, but as the tube used was very small, it was considered safer to produce further dilatation by a larger one. This was introduced April 26, but immediately rejected. The patient was seen in September, 1887. He was in good health, free from dyspnœa, and had a good voice. He wore the tracheal canula three months, and was enabled to dispense with it by wearing a tube in the larynx for one week.

With regard to the prognosis in chronic stenosis of the larynx, it would be premature to report a case as permanently cured until a long time had elapsed after final treatment, certainly more than a year. No one would call a stricture of the urethra, that required ten or more years for its development, permanently cured because it had not returned in one year after thorough dilatation or cutting. The contraction of cicatricial tissue may be very slow, and as it requires only a small portion of the normal lumen of the air-passages for free respiration, a considerable degree of contraction must exist before manifesting itself in the form of dyspnœa.

Cicatricial tissue produced by the healing of deep tertiary ulcers, if situated in the sub-glottic division of the larynx, will in all probability require occasional stretching throughout life. If, on the contrary, it is confined to the chink of the glottis, the prognosis will be better, as we here have the inspiratory abduction of the vocal cords, which must antagonize to some extent the tendency to recontraction. We know that cicatricial tissue in other parts of the body finally loses the power to contract by persistent and long-continued stretching, and if the first case reported could tolerate the tube continuously for several months instead of a week, the outlook would be better.

The third case was not due to cicatricial contraction, but to a specific inflammatory infiltration, which only required constitutional treatment for its cure, the temporary use of the tube being necessary to tide over the immediate danger of asphyxia. In Dr. Reid's case the ulceration was apparently confined to the supra-glottic region, and under proper treatment a permanent cure could be expected. In Dr. Brown's case, the removal of the foreign body left more or less thickening, and, what was probably more important, partial anchylosis of the arytenoids from want of use. In this case the prognosis is good.

In stricture of the trachea, a cylindrical tube is necessary, and I had one of this form made to use on a patient, sixty-eight years old, with a stricture of the trachea due to the pressure of a portion of a large bronchocele surrounding it. There was also so much pressure on the œsophagus that deglutition was interfered with. Intubation in a case of this kind would be very difficult, and probably would require a previous divulsion of the stricture under an anæsthetic.

There is scarcely any doubt that of all strictures, that of the trachea is the most unfavourable as regards permanent cure. The power of the contracting tissue, whether on the inside or outside, which is sufficient to overcome the resistance offered by the almost bony rings of the adult trachea, will not be destroyed by temporary dilatation.

My second case demonstrated that a tube could be worn in the larynx and trachea for an indefinite period without serious inconvenience or becoming obstructed, and suggested to me that in these obstinate cases of stricture of the trachea, it would be practicable to insert a permanent tube to prevent any recontraction after the stricture had been dilated with the regular set of instruments. I have constructed a tube for this purpose, which has a retaining swell at both its upper and its lower extremity, so that it can neither slip down nor be coughed out. Such a

tube should be made of hard rubber, burned on a framework of metal or cast in gold.

This laryngeal *speculum*, which I present, was devised to facilitate the removal of subglottic growths by holding the glottis open and the epiglottis erect.

J. O'Dwyer.

Intubation or Tracheotomy? By Dr. Max J. Stern.

The following paper considers tracheotomy and intubation, only in their relation to diphtheria and croup; for intubation has as yet been so rarely practised for the relief of other affections, that it would be unjust to draw any comparisons between the two procedures, in any other than the diseases named. Until within a recent period, there was but one method which could be employed for the prolongation of life, when asphyxia confronted us. It remained for Dr. O'Dwyer to place in our hands an instrument, the sortance of which in a little more than two years already rivals that method, for the promulgation of which Bretonneau, Trousseau, and many others have so faithfully laboured. When but one line of conduct can be employed for the relief of a particular affection, there ought be no doubt as to the manner of interference. With two methods, where the position of one is not yet determined, the particular applicability of the one or the other is the point upon which elucidation is needed. My earnest hope, therefore, is, that in the discussion which may ensue, some light be thrown upon this particular point. Tracheotomy was proposed for the relief of serious cases of angina, in remote antiquity; Coelius Aurelianus, and Galen, accrediting Asclepiades with it, in the time of Cicero. Antyllus, is the first who described a manner of operating, and is cited by Paulus Aegineta. Fabricius ab Acquapendente advised the use of a canula with wings. Casserio argued in favour of the operation, and gave a complete description of it. Rhazos, Mesue, and Avicenna spoke of bronchotomy as a supreme resource in suffocative tonsillitis. Avenzoar performed tracheotomy successfully on a goat. The operation then fell into disuse until, in 1546, Antonio Musa Brassavalo, physician to the Duke of Ferrara, performed a successful one for suffocative angina. Laryngocentesis was first performed by Santorio, about 1600, and again by Garengeot in 1748. In 1730, Dr. Geo. Martine[1] performed the first successful and recorded tracheotomy for croup, but cited earlier successes, by Mr. Baxter and Dr. Oliphant. About 1750, Heister recommended a mode of operating similar to that now practised. Decker, Bouchut, Barbeau-Dubourg and Richter, invented special bronchotomes. Tracheotomy was also recommended by Habicot, Severinus, Rene Moreau, and De Veiga. Home, about 1765, recommended it as a "dernier ressort" in croup. D'Azyr in 1776, published a work on laryngotomy. Stoll[2] in 1786, strongly advocated the operation, although he had never seen it.

---

[1] *Philosophical Transactions*, Vol. VII. No 414, p. 448, 1719-1733.
Cohen in Ashurst's Encyclopadia of Surgery, Vol. V. p. 704.

[2] Si ominibus his non, sero, vel frustra tentatis, morbus sit maxime recens et strangulans statum post acerbam prognosin instituenda exit bronchotosne. Stoll, aphorism, p. 32, bind ob, 1786.

The next credited success was that of John André, in London, 1782, and recorded by Borsieri.[1] This was followed by Thos. Chevalier, of London, in 1814, and Bretonneau after two, and according to Guersant, six unsuccessful operations, achieved his first, and the fourth recorded success in 1825. After the report of M. Royer-Collard,[3] on the Concours of 1807, the Académie de Médecine strenuously opposed tracheotomy. This was evidently to check the enthusiasm of Caron, who was its staunchest advocate, and who offered a prize of 1,000 francs to any one who would cure a case of croup by opening the windpipe.

It was Bretonneau's task to demonstrate the feasibility of the operation to the French. He and his student Trousseau remained its strongest exponents throughout their lives, and it is due mainly to the efforts of these men that the operation was perfected. Bretonneau[4] in his first operation used a goose-quill for the passage-way of air to the lungs, in the second a piece of a wax catheter, in the third a curved silver canula, which, for practical purposes, is almost identical with the single tubes until recently in use.

After Bretonneau's success the operation steadily gained in favour, and in 1835 Trousseau[5] reported sixty-one cases of tracheotomy for croup, with eighteen authenticated recoveries. They were divided among the following operators :—

Bretonneau	17 operations and	5	recoveries.
Trousseau	36 ,, ,,	9	,,
Scoutteten	1 ,, ,,	1	,,
Senu, of Geneva	1 ,, ,,	1	,,
Gerdy	1 ,, ,,	1	,,
André	1 ,, ,,	1	,,
Velpeau	1 ,, ,,	Failure.	
Guersant, jr.	1 ,, ,,	,,	
Sanson, the elder	1 ,, ,,	,,	
Blandin	1 ,, ,,	,,	

It will thus be seen that 30 per cent. of the earlier cases were saved. After 1835 the operation became general, and the reported cases rapidly multiplied, and it was not long ere the operation was performed in all parts of the world. It is almost impossible to gather any reliable statistics in the earlier years of the operation; as there is so much difference in the reports of various authors, who yet seem to have gained their information at the same sources. The most trustworthy which I have been able to find are those given in Cohen's book on *Croup and its Relation to Tracheotomy*. He has discarded all those looked upon as being doubtful. It is from this magnificent work that I have, in part, taken the statistics which I shall shortly give. Many excellent works have recently been brought forward, but none that

[1] Guersant, *Dictionnaire de Médecine*, 1835.

[2] *Med. Chir. Tran.*, VI, 1816, p. 151.

[3] Trousseau, "Tracheotomy," *Dictionnaire de Médecin*, 1835.

[4] Communication to French Academy, July, 1825.

[5] Trousseau, *op. cit.*

materially change the ultimate ratio of successes. It would indeed seem that, with all our improved appliances, the total percentage of recoveries has not increased, although occasionally we find single reports where 50 per cent. of recoveries will be noted, which is over 20 per cent. more than the gross relation. It would be unjust to take any single group of statistics, and we must deduce results from the experience of the world. Tracheotomy in the United States, until recently, has not given very encouraging results: indeed, in certain parts of the country, the mortality has been so high that the mass of the profession refuse to sanction the operation, and it is often as difficult to gain the consent of the attendant as that of the parents.

The feasibility of tubage of the larynx was accidentally demonstrated in 1801 by Desault, who passed an œsophageal catheter into the trachea, where it remained for some hours without causing inconvenience, but the patient succumbed when the bronchi were filled with food intended for the stomach. Bichat, profiting by this lesson, placed a catheter in the larynx of a patient suffering from acute œdema of the glottis. It remained *in situ* for twenty-four hours, the patient recovering. Green, Chapman, and Loiseau recommend a like procedure. In 1835, Guersant[1] reported Dupuytren's method of cleansing the trachea in croup by means of a small sponge attached to a whalebone probang, which the latter had first practised on a child of Bonaparte's Mameluke. Dieffenbach employed the same method as early as 1839. In 1854, Horace Green injected tuberculous cavities (?) by means of a flexible tube passed into either bronchus. In a case of œdema of the glottis, Hack used a Schroetter bougie for intubating the larynx. Monti, of Vienna, has for a long time employed a hard rubber tube, one end passing into the larynx the other protruding from the mouth, as a temporary substitute for tracheotomy. McEwen has employed catheters passed through the mouth to relieve dyspnœa. Reichert, Landgraf, Weinlechner, and others have resorted to the same expedient. Intubation of the larynx, as we now understand it, was first practised for the relief of croup by Bouchut, in 1857, and he reported, in 1858, to the Académie de Médecine of Paris, seven cases thus treated, two of which recovered after subsequent tracheotomy. Although the ultimate result was bad, he claimed an immediate relief of the distressing dyspnœa. Through the efforts of Trousseau, one of the Commission appointed to investigate its merits, the procedure was ridiculed and condemned, and in consequence fell into oblivion. It should be borne in mind at this time Trousseau was tracheotomy's staunchest champion. In 1880, Dr. Jos. O'Dwyer, of New York, ignorant of former efforts, began experimentation in the footsteps of Bouchut, and in 1885 published the results of his labours. His method is that of his predecessor, his instruments radically different, and are now so familiar that they need no description. Bretonneau said: "A large increase in the fatality of tracheotomy must be set to the negligence or ignorance of surgeons who imagine, with the performance of the operation, all has been done that is required" I know from my own experience that this can be applied to intubation, the operator

[1] *Dictionnaire de Médecine*, Paris, 1835.

not having had the wit to discern that he had but eliminated one factor to be combated in these dread diseases. While this, of course, is applicable to but few, it, nevertheless, lowers the ratio of success. The reports various operators have recently published, in reference to intubation, have sufficed to enable me to present a reasonable number of cases, which we will proceed to dissect and compare with the results of tracheotomy.

The number of tracheotomies derived from French sources were in part gleaned from *Cohen's Croup* [1], and in part from *Sanné's Diphth-*

Operators.	No. of Cases.	Recoveries.
[1] Amussat	6	0 *a*
Baudelocque	15	0 *a*
Blandin	5	0 *a*
Bretonneau	18	4 *a*
Serdy	6	4 *a*
Roux	4	0 *a*
Trousseau	80	20 *a*
Velpeau	6	0 *a*

a Cohen's Croup, Philadelphia, 1871.

Gosselin	25	0 *b*	
Michon	29	2 *b*	
Langier	8	1 *b*	
Nelaton { Before 1848	23 }	Before 1848	0 *b*
{ After 1848	13 } 36	After 1848	13 *b*
Monod, Jr. (about)	40	0 *b*	
Sheirry (in children)...	37	3 *b*	
,, (in adults)	3	0 *b*	
Malgaigne	8 (or ten)	1 *b*	
Bardinet (and *confrères* at Limoges)	57	17	
Sausier (Troges)	6	3	
Beylard (Paris)	13	4 *c*	
Moynier (Paris)	17	8 *c*	
Archambault (Paris)	24	8 *c*	
Perrochand (Boulogne)	3	2	
Delarue (Paris)	3	1	
Salvis (Belleville)	6	3 *b*	
Viard (Montbard)	2	1	
Petel (Cateau)	9	5 *c*	
Baudin (Nautua)	4	3	
Dubarry (Condom)	5	2	

[1] *Gaz. Hebd.*, December 5, 1856, p. 844. Cohen's Croup.

Richet	9	5
Follin	7	2
Broca	12	6

a Bull. de l'Acad. de Méd., [illegible]
b Bull. de l'Acad. Méd., XXIV, p. 231.
c Bull. de l'Acad. Méd., XXIV, p. [illegible] Cohen's Croup.

theria[1]; the latter having personally examined the hospital registers. We can then gather from France 5,151 tracheotomies; of these there were 1,306 recoveries, or a ratio of 22 6-10ths per cent. From Portuguese sources[2] we get 59 operations, with 21 recoveries, or 35 5-10ths per cent. From Belgium,[3] reported by Henriet and Warlomont, we have 43. cases and 12 recoveries, or 27 9-10ths per cent. From Germanic[4]

Operator.	No. of Cases.	Recoveries.
Richard	5	2 *c*
Demarquay	6	2 *c*
Rousseau (1851-54, private practice)	24	14 *c*
Isnard...	4	2 *c*
Baizeau (Paris)	12	2 *c*
Boeckel (Strasbourg)	33	12 *c*
Schoeilhammer (Haut Rhin)	7	6 *c*
Other operators	43	16 *c*
Calvet (Castred)	23	13 *c*
Hennette (Brussels)	8	4 *c*

[1] *Gill's-Sanné, Diphtheria*, St. Louis, 1887, pp. 467-8.

Operator.	No. of Tracheotomies.	Recoveries.
[2] Antonio Maria Babbosa	23	9 *d*
Theotonio da Silva	21	8 *d*
Other operators	15	4 *d*
	59	21

Operator.	No. of Cases.	Recoveries.
[3] Henriet	8	4 *e*
Warlomont (St. Peter's Hospital, Brussels) ...	35	8 *e*
	43	12
[4] Passavant (Frankfort) from 1851 to 1882	229	67 *f*
Baum (Svettingen)	31	12 *f*
Fock and others (Magdeburg)	43	18 *f*
Roser (Marbourg)	42	19 *f*
Midé and others (Braunschweig)...	81	21 *f*
Simon (Rostvik) one in an adult; terminated fatally)	22	6 *f*
Burow (Koenigsburg)	50	7 *f*
Schmidt	15	2 *f*
Leipsic City Hospital, from 1878 to 1883... .	310	67 *f*
Peltzer (Brennen, from October, 1883, to March, 1884	88	12 *f*
Bartels (Kiel)	61	17 *f*
Max Bartels (Berlin), *Statistics of the Operations Performed in the Service of Prof. Wilms, at the Bathanien Hospital, from* 1861 *to* 1872, and comprise the 100 published by Sfterboch in 1867	335	103 *f*

d Gill's-Sanné, *op. cit.*, p. 470.
e Gill's-Sanné, *op. cit.*, p. 471.
f Gill's-Sanné, *op. cit.*, p. 472-3.

sources we gather 1,837 cases, showing 558 recoveries, or 30 4-10ths per cent. In Switzerland Dr. D'Espine[1] reports 148 operations and 57 recoveries, or 38 5-10ths per cent. From England[2] we can obtain

Operator.	No. of Cases.	Recoveries.
Eberth (Berlin), from 1857 to 1865	13	6 *f*
Busch (Berlin)	72	10 *f*
Von Kopl	17	11 *f*
Morath	1	1 *f*
Stelzner (Dresden)	12	4 *f*
Muller (Cologne), from 1862 to 1869	45	15 *f*
Molard Ziniski (Lemberg) (one an adult) ...	2	0 *f*
Oelschlaeger (Danzig), 1856 to 1869	12	1 *f*
Reiffer (Frauenfeld)	18	8 *f*
Heuter (Rostock)	29	7 *f*
Birnbaum (Darmstadt), 1873 to 1883	140	47 *f*
Van Arsdale, *Annals of Surgery*, Vol. I, No. 2, 1885	88	76 *f*
Harmer (Munich)...	17	2 *f*
Fifty-eighth Congress of German Naturalists and Physicians, Strasburg, September 18th to 23rd, 1885 (*Medical Record*, November 14th, 1885), Ranke (Munich), tracheotomy 7½ years	45	10 *f*
	1837	558
[1] Billroth (Zurich)	12	1 *s*
Revilliod (Geneva)	87	38 *s*
D'Espine (Geneva)	15	6 *s*
Picot (Geneva)	4	3 *s*
Papin (Geneva)	30	9 *s*
	148	57
[2] Spence (Edinburgh)	87	28 *h*
Buchanan (Glasgow) . .	30	13 *f*
Comehoshank	11	8 *h*
H. W. Fuller, Statistics of .	7	3
Conway Evans	5	1
Henry Smith (London) .. .	3	0
Ronson (Nottingham) . .	3	0
West London	30	7
Dickinson	18	0
Fagge	43	7
Gee, from 1853 to 1878 . .	34	3
R. W. Parker	32	17
	127	33

Dickinson, *Transactions of the Royal Medical and Chirurgical Society*, 1879.

[1] Gill's Sa... *Rev.* ... p. 45.
[2] Gillett's Sa... *Rev.* ... p. 45.
[3] Gillett's Sa... *Rev.* ... p. 174.
[4] Gillett's Sa... *Rev.* ... p. 45.

332 tracheotomies, showing 97 successful cases, or a ratio of 29 2-10ths per cent. Wm. M. Masten [1] has collected from American sources 860 operations, showing 195 cures, or 22 7-10ths per cent. of recoveries. This would give in all 8,380 cases, with 2,225 recoveries, or 26 4-10ths per cent. Certainly not an enviable showing, and yet the percentage in individual reports occasionally runs very high; thus the statistics of the Annen-Kinderspital, in 1884, showed over 50 per cent. of recoveries.

In 1878, Agnew [2] reported 11,696 cases, of which 26¼ per cent. recovered. Monti,[3] of Vienna, in 1884, published 12,736 operations, showing 3,409 recoveries, or 26 8-10ths per cent.

Lovett and Monroe [4] have published in July of this year 21,853 operations, showing 6,135 recoveries, or 28 per cent.

Although our number of intubations are still comparatively limited,[5] I have yet been enabled to collect 957 cases, showing 252 recoveries, or 26 2-5ths per cent. of those operated upon.

This, in all probability, judging from a comparison of tracheotomy in its earliest days with the result in the present time, will remain about the established ratio. Among certain individual operators the proportion of recoveries is very much higher, among others it is far below the mean percentage. Taking into consideration the liability to recover in certain epidemics, and *vice versâ* in others, I do not think, even with improved instruments, such as are already being experimented with, the ultimate ratio of recovery to operation will be greatly altered. This is subject to the proviso that the constitutional treatment of the disease remains unchanged. Intubation and tracheotomy are not practised to cure the disease, but simply that air may be conveyed to the lungs. This O'Dwyer's tubes now accomplish, and this the various tracheotomy canulæ have always performed. Accidents in either procedure—the word is advisedly used—are responsible for a comparatively small number of deaths.

Hospitals.—	No. of Cases.	Recoveries.
St. George's (one of the fatal cases was sixteen years old)	6	3 *l*
Dreadnought Hospital Ship	1	0 *l*
Metropolitan Free Hospital	1	0 *l*
Hospital for Sick Children	3	0 *l*
King's College Hospital	1	0 *l*
Middlesex Hospital	6	0 *l*
St. Mary's Hospital	1	0 *l*
Addenbrooke's Hospital, Cambridge	1	1 *l*
	20	4

[1] *Annals of Anatomy and Surgery*, 1881.
[2] Agnew, *System of Surgery*, Vol. III. 1878.
[3] *Annals of Anatomy and Surgery*, Vol I, p. 581.
[4] Lovett and Monroe, *American Journal of Medical Sciences*, July, 1887.
[5] *Appended Statistics.*

l Sanné *op. cit.*

Tracheotomy gives us 26½ per cent. of recoveries. Intubation shows 26 2-5ths per cent. ; not an appreciable difference ; yet marked variances are found on analysis. Owing to incompletely reported cases only a part of them were available for classification. Sex would seem to have a decided bearing upon the results ; thus, of 448 cases, in which I could ascertain the gender, 236 were boys and 212 girls. Of the boys 78 recovered, of the girls 51, showing the ratio of recovery in males to be 33 1-20th per cent., in females 24½. This may be a mere coincidence, although the excess of recoveries in favour of males was even more marked in the earlier cases. Why this difference should exist I do not know, although it may be a point for further consideration. Fisher and Brichetau [1] reported 396 tracheotomies, of which 225 were in males, of whom 38 recovered, and 171 in females, of whom 29 recovered ; showing 17 per cent. of recoveries in both sexes. Bourdillat's [2] analysis of 1,300 cases also showed no difference in favour of either sex. Yet, at various times, statistics have shown a marked preponderance of recoveries in either gender.

I have been able to analyse 519 cases of intubation with reference to age and result, and will compare them to Bourdillat's [3] statistics of tracheotomy. The 143 intubation cases, which recovered, show a slight increase of 1 1-5th per cent. over the gross result. These may be divided as follows :—

	Intubations.	Recoveries.	Per cent.	Per cent. of Tracheotomy Recoveries.
Under 2 years	110	17	15½	3 [4]
Between 2 and 2½ years	53	13	24½	12
,, 2½ ,, 3½ ,, ...	135	39	28 9-10	17
,, 3½ ,, 4½ ,, ...	86	29	33 7-10	30
,, 4½ ,, 5½ ,, ...	60	17	28 3-10	35
Over 5½ years	75	28	37 3-10	39½

Bourdillat's ratio for recoveries, under two years, seems much lower than those of other statisticians ; an average of most of them would bring it about 6 per cent., and this I have taken for those years.

We find, then, that intubation practised on children—

Under 2 years gives a gain of	9½ per cent.
Between 2 and 2½ years gives a gain of	12½ ,,
,, 2½ ,, 3½ ,, ,, ,, ,, ...	11 9-10 ,,
,, 3½ ,, 4½ ,, ,, ,, ,, ...	3 7-10 ,,
,, 4½ ,, 5½ ,, a loss of ,, ...	6 7-10 ,,
Over 5½ years gives a loss of	2 2-10 ,,

[1] *Traitment du Croup ou Angine laryngée diphthéritique*, second edition, Paris, 1863.

[2] Bourdillat, *Bull. et Mem. Soc. Med. Ho.*, Paris, 1887, p. 39. Cohen, *op. cit.*

[3] Bourdillat, *op. cit.*

[4] Trousseau, *op. cit.*

The youngest recovery in intubation was six months old; in tracheotomy Scoutteten[1] reports the case of his own child at six weeks, but the correctness of his diagnosis has been so invariably questioned that it might be eliminated. The next youngest tracheotomies that recovered were those of Croft[2] at five months; Kisler[3] at six months; Tait[4] and Bell[5] each had one at seven months. The oldest intubations to recover were those of Van Fleet[6] and Langman[7] at eleven years, and Austin G. Cases'[8] at ten and a half years. A child of fourteen years was the oldest intubation recorded. Recovery in tracheotomy has, at rare times, been reported in adults.

Among the difficulties to be surmounted in the performance of tracheotomy in children is obtaining the parents' consent; this is also experienced in intubation, although rarely to so marked an extent. The difficulty of obtaining an attendant who is familiar with, and skilled in the after-treatment of a tracheotomized patient, is one of the greatest objections to this interference. Many of the writers upon intubation tell us that after its performance no skilled attendance is necessary. I think any one who will closely study the reported cases will see the fallacy of this statement. In one of the cases which I have reported the attendant left the house for a few minutes to mail a letter; upon his return he was horrified to find the child suffocating. It died during attempted removal of the tube, which had become choked with membrane. But there is less danger in the after-treatment of intubation than of tracheotomy—infinitely less, I think. We hear much of the ease and facility with which intubation is practised—this is misleading; to one familiar with laryngeal work it is no great task. I had a gentleman try and intubate my own larynx, and now I appreciate the difficulty of intubation when the obturator is not in a laryngologist's hands. Inquiry among many who practised intubation substantiates these views. If the introduction of the tube is difficult, the removal is infinitely more so, and not a few patients have been killed in the latter attempts.

Tracheotomy is an exceedingly difficult operation in young children, becoming less so as age advances, but always remaining an extremely delicate one. Much has been written about shock. Now, patients do not die of shock after tracheotomy. They do die immediately after or sometimes during the operation, but it is never of shock. It is of the effects of the disease itself, or the result of accidents during the operation. Tracheotomy requires, ordinarily at least, one skilled assistant, intubation none. In tracheotomy the foods most readily assimilated may be given; in intubation only solids or semi-solids may be ingested. In intubation the dangers of erysipelas and emphysema, local and general, and the

[1] *American Journal of Med. Sciences*, 1844, April, p. 466.
[2] *Lancet*, November, 1880, p. 849.
[3] *Deutsche Medizinische Wochenschrift*, No. 45, 1887.
[4] *British Medical Journal*, April 15, 1871, p. 391.
[5] *Syme. Ed. Med. Journal*, 1861, p. 956.
[6] *New York Medical Journal*, 1887, XXXII. 103.
[7] *New York Medicinische Presse*, 1887, III. 259.
[8] *Medical Review*, Pittsburg, 1887, I. 114.

consequently bad results, are not incurred. In no case of intubation has the tube been worn over twenty-one days,[1] and even that was exceptionally long, the majority retaining them from the fourth to the ninth day. In tracheotomy it is not at all unusual for a child to wear a tube fifty days, and Steiner reports one in which the tube was retained one year and three months. An unfortunate circumstance in connection with tubage is the dying of the patient upon the introduction of the instrument, through the crowding down of membrane, or the plugging of the tube. One of the greatest advantages of intubation is that a patient can be intubated much earlier than tracheotomized; consent can more readily be gained, and the attendant, I think, will be more likely to perform it; with tracheotomy he is apt to postpone the performance a little more and more, hoping for a favourable turn, and urged thereto by the enormous labour entailed in the after-treatment. One of intubation's best features undoubtedly is, that it does not preclude a subsequent tracheotomy. Another feature of inestimable value is that the air reaches the lungs in the normal manner.

The grave question now remains, when shall tubage be done and when tracheotomy performed?

1. All things being equal, I would always intubate where the patient is under three and a half years of age.

2. Between the ages of three and a half and five years, I would be regulated, of course, by individual circumstances, with a preference for tracheotomy.

3. Over five years of age I should perform tracheotomy.

4. In adults I would never tracheotomize, but willingly test intubation.

5. Among poor people, irrespective of age, I would always intubate. While it may sound harsh to draw such class distinction, good reasons are forthcoming. The general results of intubation are about equal to those of tracheotomy. Skilled attendance, such as is always required after tracheotomy, can only be procured for considerable purchasing power, and is in consequence only available where people have means. While the operator himself may be willing to give his own valuable time, he may owe to other patients attendance that may be of as much value to them as to the child operated upon.

6. Intubation should never be performed at any age, when there is a strong probability that the trachea is crowded with membrane.

7. Where skilled assistance cannot be obtained intubation should always be practised.

I should not like to close the paper without a slight tribute to the labours of Dr. O'Dwyer, who, through his perseverance and patient period of experimentation, has placed in our hands a procedure that will probably save many, many lives. Had he, upon the incipiency of the experiments, followed Bouchut's plan of immediately publishing his results, would it not again have shared a like fate? Which of us may not yet have cause for a personal debt of gratitude to this modest inventor?

[1] Montgomery, *Personal Communication*.

OPERATORS, NUMBER OF CASES OPERATED UPON, AND NUMBER OF RECOVERIES.

Operator.	No. of Cases.	No. of Recov's.	Operator.	No. of Cases.	No. of Recov's.
Jos. O'Dwyer... ...	137	27	Carl Beck	5	4
F. E. Waxham ...	131	34	James McManus ...	5	2
Dillon Brown ...	87	18	F. K. Priest	5	0
F. Huber	47	20	Forscheimer	5	2
J. M. Bleyer	42	11	B. T. Shimwell[1] ...	4	2
D. O'Shea	37	14	G. W. Gay	4	0
W. P. Northrup ...	32	6	F. C. Shaffer... ...	4	0
A. B. Strong... ...	31	1	Geo. Thilo	4	3
C. E. Denhard ...	24	10	H. D. Ingraham ...	3	0
F. Van Fleet... ...	22	7	A. S. Hunter ...	3	0
D. C. Cocks	21	6	G. W. Mason ...	3	1
T. H. Meyers ...	21	3	F. W. Merriam ...	3	2
E. E. Montgomery[1] ...	21	11	S. A. McWilliams ...	3	0
A. Caille	15	5	H. Boenning[1] ...	3	1
W. Cheatham ...	15	1	M. J. Stern[1]	3	1
G. H. Cocks	14	4	Rehfuss[1]	3	2
E. F. Ingalls... ...	12	3	N. S. Roberts ...	2	1
J. Tasher	11	4	W. E. Shaw	2	0
W. K. Simpson ...	10	0	J. L. Mulfinger ...	2	1
J. A. Anderson ...	10	1	S. Solis-Cohen[1] ...	2	0
E. L. Cocks	10	3	David Prince... ...	2	2
J. J. Reid	10	4	W. L. Carr	2	0
Geo. McNaughton ...	10	2	Hailes..	2	2
C. G. Jennings ...	10	0	J. W. Niles	1	0
A. E. Hendley ...	9	0	L. L. Palmer ...	1	0
F. Henrotin	9	3	A. G. Case	1	1
H. W. Berg	8	2	Frank Tipton ...	1	1
L. H. Dunning ...	7	2	Langman	1	1
J. Eichberg	6	2	Rihl	1	0
H. H. Mudd... ...	6	2	T. G. Morton ...	1	0
I. H. Hance	6	1	E. C. Morgan ...	1	0
J. E. Winters ...	6	0	J. B. Wheeler ...	1	0
J. Salinger[1]	6	3	H. F. Ivins	1	0
Hopkins	6	6	F. Donaldson, Jr. ...	1	0
H. O. Bates	6		Charles Dennison ...	1	1
W. H. Preston ...	6		E. D. Fergueson ...	1	0
W. P. Boles ...	2	2	James Collins ..	1	0
H. L. Smith ...	2				

Number of operators	75
Number of cases	957
Number of recoveries	252

REFERENCES AND BIBLIOGRAPHY OF INTUBATION.

Medical Record, New York, 1885, February 21st. 1886, XXIX. 410. 1886, XXIX. 641. 1886, XXX. 487. 1886, XXX. 645. 1886, XXX. 683. 1887, XXXI. 26. 1887, XXXI. 108. 1887, XXXI. 324. 1887, XXXI. 677 to 687. 1887, XXXI. 608. 1887, XXXI. 705 to 707. 1887, July 2nd., XXXII. 1887, July 9th, XXXII. 1887, XXXII. 99 to 106.

[1] Personally communicated to the writer from notes.

New York Medical Journal, 1885, XLII. 145. 1886, XLIII. 384. 1886, XLIV. 373. 1886, XLIV. 322. 1887. XLV. 238. 1887. XLV. 273. 1887, XLV. 624 1887, XLV. 640. 1887, XLVI., II. 1887, XLVI. No. 5.

Journal American Medical Association, 1886, VI. 147. 1886, VI. 186. 1886, VI. 426. 1886, VII. 35. 1887, VIII. 199. 1887, VIII. 342. 1887, VIII. 337. 1887, VIII. 359. 1887, VIII. 291. 1887, VIII. 701. 1887, IX. 135.

Letter to E. Fletcher Ingalls. Reprint from the *New York Medical Journal*, July 2nd and 9th, 1887.

Statistical Records of Intubation, *Medical Record*, July 23, 1887; *New York Medical Journal*, August 8, 1885.

Transactions of the American Laryngological Association, 1887.

Chicago Medical Journal and Examiner, 1885, L. 475. 1885, LI. 511. 1886, LIII. 132. 1886, LII. 214. 1885, LI. 401.

Medical and Surgical Reporter, 1886, LV. 586.

New Yorker Med. Presse, 1887, III. 259. 1887, June.

Medical Register, 1887, I. 174. 1887, I. 146.

Medical News, 1887, L. 341. 1887, L. 630.

Maryland Medical Journal, 1886, XVI. 67. 1886, XVI. 168.

Medical Review, Pittsburg, 1887, I. 114.

Weekly Medical Review, St. Louis, 1887, XV. 57.

Pacific Medical and Surgical Journal, 1887, XXX. 129.

Chicago Medical Times, 1887-88, XIX. 53.

Cincinnati Lancet and Clinic, 1887, N.S., XVII. 97. 1887, N.S., XVIII. 321.

Hahnemannian Monthly, June, 1886.

American Practitioner and News, 1886, N.S., II. 321.

St. Louis Medical and Surgical Journal, 1887, LII. 115.

American Lancet, Detroit, 1886, N.S., X. 401.

Canadian Practitioner, Toronto, 1887, XII. 1.

Archives of Pediatrics, 1885, II. 657. 1886, III. 215. 1887, IV. 154.

Medical Age, Detroit, 1886, IV. 313.

Mississippi Valley Medical Monthly, 1886, VI. 345.

Albany Medical and Surgical Journal, 1887, II. 331.

Boston Medical and Surgical Journal, 1887, CLVI. 518.

American Journal of Obstetrics, 1816, June 17.

REVIEWS.

CHIARI (Vienna).—**Observations on Diseases of the Throat and Nose.** *Toplitz and Deutiche, Leipzig and Vienna*, 84 pages.

THE author relates observations on more than 2,000 patients seen in the clinic of Prof. Nothnagel, many of which are very interesting. One case of laryngitis hæmorrhagica (Strübing) was combined with a fibroma; acute subglottic laryngitis (chorditis hypertrophica inferior) was seen in two cases. Chronic laryngitis was treated with nitrate of silver and iodized glycerine. Once a case of circumscribed abscess of the vocal cord occurred: cured by incision and removal of the pus. Phlegmonous inflammations of the larynx occurred seven times. In two cases of tuberculosis, tracheotomy was necessitated by reason of stenosis. Lactic acid is preferred for the

treatment of tubercular ulcers. The use of cocaine in laryngeal operations is discussed. Intoxications are rare, and are due to idiosyncrasy. The author favours Voltolini's sponge method for papillomata, which, however, recur after every method of operation. Cysts of the vocal cord were seen in two cases, and one was operated upon. Five cases of carcinoma were seen, and two were cured by extirpation of the larynx. Stenoses are treated with Schroetter's tin and hard rubber bougies.

Many cases of laryngeal paralysis were seen, two of aphonia spastica, and one of chorea laryngis. Compression of the trachea was met with in ten cases of struma. Many cases of reflex neuroses of the nose were seen, and local applications, particularly of the galvano-cautery, were most beneficial.

Ozæna was treated with ½ per cent. salt irrigations, and eczema with diachylon ointment. A frequent cause of epistaxis was noted in enlarged vessels of the septum and excoriations of this locality, and the galvano-cautery was the best treatment. Polypi and other growths in the nares were operated on by galvano-cautery, cold wire, or forceps.

A rhinolith was found in one case. Adenoid vegetations were operated on with cutting forceps. **Michael.**

HERING, T.—The Curability of Laryngeal Phthisis by Surgical Methods. A work based on Microscopic, Anatomico-Pathological, and Clinical Observations. *Warsaw*, 1887.

THIS is a very careful work, illustrated with many plates, and deals with the etiology and pathological anatomy, and pathological proofs of the curability of phthisical ulcers of the larynx; a description of the surgical methods invented and employed by the author, viz., curetting, frictions, and injections of lactic acid, and injections of iodoform emulsion; a description, with drawings, of the instruments invented by the author; and lastly, the history of thirty-five cases in which these methods were employed. From the author's observations, the conclusions are arrived at, that laryngeal phthisis ought to be treated locally by surgical methods, just as tuberculosis of other organs accessible to surgical manipulations; that by following these methods cicatrization of ulcers can be procured, and a more or less lasting cure, with disappearance of the sufferings of the patient, and gain in strength. Recurrences, however, occur from time to time, and the cure of these ulcers does not influence the progress of the disease in the lungs. Speaking in general terms, this work is careful, giving conclusions which are not too optimistic, even for an author so enthusiastic of his ideas and methods. Hering's treatment consists in the following:—

1. At the commencement of the disease, parenchymatous injections of iodoform emulsion, or of 10 per cent. to 20 per cent. lactic acid, should be made into the larynx.

2. During the stage of softening and inflammation of the infiltrated parts, deep incisions into the affected parts (epiglottis, posterior wall of the larynx, aryepiglottic ligaments), or extirpation of the affected parts by means of forceps, guillotines, and curettes, should be performed. Anæsthesia should first be obtained by 10 per cent. solution of cocaine,

or by injection into the mucous membrane of the affected parts of five to eight drops of 10 per cent. cocaine (with the addition of 2 per cent. carbolic acid) by means of the author's syringe. Having extirpated the affected parts with the curette, Hering continues local treatment with iodoform, iodol, or lactic acid. In twenty-eight cases the author has succeeded in obtaining complete cicatrization of tubercular ulcers.

Const. Karwowski.

NOTES.

A Correction.—Dr. E. F. Ingals desires us to correct a misprint which unfortunately occurred in the report of his article on Intubation (see Vol. I. p. 377). Instead of saying that "all foods should be prohibited except by enemata," it should have been "all fluids." The impression which might apparently be conveyed that two of his three successful cases subsequently died is not what was meant by the abstractor. Dr. Ingals's three successful cases are still living.

The Index to the first volume will be forwarded to all subscribers in the course of a few days.

London : Pardon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

THE "MINIATURE"

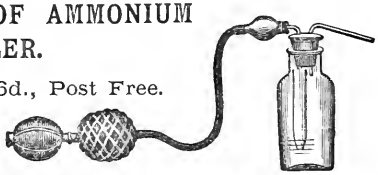
THROAT & NASAL SPRAY APPARATUS

For the Application of Solutions (Cocaine, Quinine, etc.) in the form of Spray.



THE PATENT CHLORIDE OF AMMONIUM VAPOUR INHALER.

Spray, 2s. 6d.; Inhaler, 3s. 6d., Post Free.



SYMES & CO., LIVERPOOL.

MARTINDALE'S GLASS CAPSULES,

Encased in Cotton Wool and Silk, easily fractured, contain respectively the following Medicaments for Inhalation, sold in Boxes at 2s. 6d. each. viz.:—**NITRITE OF AMYL** (for Angina Pectoris, Sea Sickness, Asthma, etc.), **IODIDE OF ETHYL, BROMIDE OF ETHYL,** and **CHLOROFORM** (for Asthma, etc.).

PASTILLUS COCAINÆ. $\frac{1}{20}$, $\frac{1}{10}$, or $\frac{1}{5}$ grain each. For allaying irritation of the Throat and giving Tone and Flexibility to the Vocal Organs.

COCAINE HYDROCHLORATE, in pure Crystals.

NASAL BOUGIES (BUGINARIA) OF COCAINE, COCAINE AND ATROPINE (for Hay Fever), **IODOFORM, DI-IODO-SALICYLIC ACID** (have effect of Iodoform without the odour), **SULPHATE OF COPPER, etc.**

PEPTONIZED BEEF SUPPOSITORIES, for Rectal Alimentation.

PORTABLE INHALER, with Thermometer. Price 6s. 6d.

POOR MAN'S INHALER. Price 2s. Received Award of Merit from International Medical and Sanitary Exhibition, London, 1881.



W. MARTINDALE, Pharmaceutical Chemist,
10, NEW CAVENDISH STREET, LONDON, W.

ELECTRO-MEDICAL INSTRUMENTS

OF THE LATEST PATTERNS AND LOWEST PRICES.

PRICE LISTS FREE.

EVERY DESCRIPTION OF INSTRUMENT FOR THE GALVANO-CAUTERY.

J. B. THISTLETON,

I, OLD QUEBEC STREET, OXFORD STREET, W.

Electrician to the Throat Hospital, etc.

BULLOCK'S

PASTILS OF COCAINE ($\frac{1}{20}$, $\frac{1}{10}$, & $\frac{1}{5}$ grain). Belladonna, Iodoform, Bismuth, Bismuth and Morphia, &c.

NASAL BOUGIES. Iodoform, Bismuth, Belladonna, Sulphate of Copper, &c.

MEDICATED WOOLS, for Nasal Use. Iodoform (50%), Perchloride of Iron, Cubeb, Boric Acid, Opium, Rhatany, Eucalyptus, &c.

LOZENGES, with Black Currant Basis. Rhatany, Kino, Benzoic Acid, Cubeb, Guaiacum, Chlorate of Potash, Eucalyptus, &c.

IMPROVED GREGORY'S POWDER. Greatly condensed, freed from inert matter, and devoid of objectionable taste.



THE UNIVERSAL INHALER.

IMPORTERS OF OLEUM PINI SYLVESTRIS, FOR INHALATIONS, &c.

J. LLOYD BULLOCK & CO.,

3, HANOVER STREET, HANOVER SQUARE, W,

Contents.

Abdominalis. HUNT: Laryngeal Polypi. SCHUCHARDT: External Laryngotomy for Laryngeal Tumours. TISSIER: Cancer of Larynx. THACHE: Cancer of Larynx. MONOD: Cancer of Larynx. BEALE: Lymphoma Affecting Larynx. STEVEN: Thoracic Aneurism. BARLOW: Laryngismus Stridulus. GORDON HOLMES: Paralysis of the Abductors of the Vocal Bands. LANDGRAF: Aphonia Spastica. MÜLLER: Paralysis Agitans. DEFONTAINE: Tracheotomy. VANIOPY: A Needle Ten Months in the Larynx. DAUVIN: Laryngeal Vertigo.

Neck, &c., p. 76.—GIBB, W. F.: On Scrofulous Neck. VIGOUROUX: On the Treatment of some Peculiarities of Basedow's Disease. CRAMER: Struma Maligna. ROSENBACH: On Nervous Cough. FOXWELL, A.: Viennese Notes. BATUT: Study of Hygroma of the Thyro-hyoidean Bursa. DUFFY and WILKS: Discolouration of the Skin by Nitrate of Silver. STOKES, Sir W.: Inaugural Address on Work done in Surgery, &c. SCHEUERLEN and SCHILL: Bacillary Origin of Carcinoma.

Association and Congress Meetings, p. 78.—60th Meeting of German Naturalists and Physicians. 9th International Medical Congress: Papers by Dr. Casselberry, Nasal Fibromata; Dr. J. Ege, New Treatment of Phthisis. 6th International Congress for Hygiene, &c. French Association, Toulouse Meeting.

Societies, p. 87.—Surgical Society of Paris; Academy of Medicine of Paris: Medical Society of Warsaw; Berlin Medical Society; Society of Physicians, Vienna; British Med. Association—Birmingham and Midland Counties Branch; New South Wales Branch; Dorset and West Hants Branch; Brighton and Sussex Medico-Chirurgical Society: Cambridge Medical Society: Northumberland and Durham Medical Society; Pathological Society of London; Harveian Society of London; Medical Society of Manchester; Leeds and West-Riding Medico-Chirurgical Society.

Reviews, p. 93.—Greville Macdonald, "The Forms of Nasal Obstruction, Lennox Browne, "The Throat and its Diseases;" Renault, "Manual of Tracheotomy."

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés *d'envoyer un numéro de tout journal* contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Um die rechtzeitige Veröffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W., zu senden.

Throat and Lungs.

New and Improved Agents.

As contributing to physicians' convenience, we have prepared a *throat case* which may be fitted with a complete list of agents prepared in the most desirable form.

Price to the Medical Profession: Calf case, containing 16 3-drachm vials, filled, 25s.

Absorbent Cotton (Lawton's).

For Surgical and Dental purposes. This is perfectly homogeneous, snowy white, of downy softness, and will absorb over a dozen times its weight of water.

Supplied to the medical profession in packets, 2 oz., 4 oz., and 1 lb., at 8d. 1s. 1d. and 3s. each. Retail prices, 1s., 1s. 6d., and 4s.

Ammonium Chloride Tabloids.

"Ammonium Chloride considerably increases the secretion from the mucous membrane," and prevents the formation of thick tenacious mucus. Aside from its value in neuralgia, its usefulness in catarrhal conditions of the throat and lungs is well known. For the throat, it should be dissolved on the middle of the tongue—not near the tip.

Dose.—One to six tabloids with plenty of water.

Supplied to the medical profession in packages of 30 and 100, at 5d. and 1s. 1d. Retail prices, 6d. and 1s. 6d.

Sal Prunella Tabloids.

"A popular remedy, sometimes successful in mild cases of incipient inflammatory sore throat, is a small piece of nitre allowed to dissolve slowly in the mouth" (Waring). It is "an excellent saline for throat cases, nor is it destitute of local efficacy. Mixed with sugar and slowly dissolved on the tongue [or preferably in the form of Tabloids], it is a popular remedy, and for mild inflamed sore throat its ancient reputation is deserved."

Directions.—One or more (5 gr.) Tabloids should be dissolved slowly in the mouth for the local effect.

Supplied to the medical profession in bottles of 100 at 1s. 10d. Retail price, 2s. 6d.

Pinol (Burroughs).

This is the pure essence of the pumilio, a pine which grows on the snowy heights of the Alps, and distinguished from the ordinary pine oils by superior medicinal and sanitary properties and rare and exquisite fragrance. It is widely prescribed for nasal catarrh, pharyngitis, quinsy, clergyman's sore throat, aphonia, asthma, pertussis, chronic bronchitis, bronchorrœa, and phthisis.

It may be used in a spray or steam atomizer, or in the Burroughs Chloride of Ammonium Inhaler, also as a gargle and for fumigations. It may be taken internally in three drop doses on a lump of sugar. The Pinol Pastilles are really pleasant, delicate sweets.

Supplied to the medical profession in bottles at 1s. 3d. and 2s. Retail prices, 1s. 6d. and 2s. 6d.

Pure Terebene (Burroughs).

Report of Mr. R. M. Lucy, of South Devon and East Cornwall Hospital:—

"The Terebene we have used in a bad case of bronchitic asthma with the best results. No irritation of the throat as one finds with crude preparations! In fact, the patient could not take the so-called 'Pure Terebenes' other than 'Burroughs'."

Supplied to the medical profession in 1-oz. and 2-oz. bottles, at 9d. and 1s. Retail prices, 1s. and 1s. 6d.

Voice Tabloids.

The Voice Tabloids are composed of COCAINE, Chlorate of Potash and Borax.

"Chlorate of Potash is chiefly used to bring about a more healthy condition of the mucous membrane of the mouth and throat" (Wood).

Borax is considered an excellent antiseptic, correcting perverted oral secretions, cleansing the mouth, and imparting to an offensive breath the wholesomeness of health.

In catarrhal and other diseased conditions of the throat cocaine is very grateful, affording relief from irritation and pain.

The best way to employ COCAINE for the throat is in the form of the Voice Tabloids.

Supplied to the medical profession in packages of 30 and 80, at 8d. and 1s. 4d. Retail prices, 1s. and 2s.

Compressed Chlorate of Potash Tabloids.

In acute sore throat, Chlorate of Potash "usually relieves the uneasiness in a few hours" (Cohen).

Supplied to the medical profession in packages of 30 and 100, at 4d. and 9d. Retail prices, 6d. and 1s.

Chlorate of Potash and Borax Tabloids.

Prescribed for aphthous ulceration, cracked tongue, hoarseness, clergyman's sore throat, and aphonia. "The Tabloids are manufactured with the utmost neatness and perfection" (BRITISH MEDICAL JOURNAL).

Supplied to the medical profession in packages of 30 and 100, at 4d. and 9d. Retail prices, 6d. and 1s.

THE
JOURNAL OF LARYNGOLOGY
AND RHINOLOGY.

VOL. II. FEBRUARY, 1888. NO. 2.

A CRITICAL AND EXPERIMENTAL ESSAY ON THE TENSION OF THE VOCAL BANDS.[1]

THE earliest investigators on the mechanism subserving the longitudinal tension of the so-called vocal cords, once acquainted with the distal attachments of their longitudinal elements, naturally located the active forces regulating their tension in the muscular apparatus having under its control such displacements of the thyroid and arytenoid insertions as directly influenced their length, and, as a matter of course, the solution of a problem was sought in the study of the anatomy and physiology of the thyroid and cricoid cartilages, the crico-thyroid articulations, and the set of muscles connected therewith. The relative simplicity of this group of anatomical elements soon afforded a most accurate morphological description, and their superficial situation rendered it exceedingly easy to investigate experimentally the effects of the muscular action on the cartilaginous organs between which the vocal ligaments are stretched. But there must be some fundamental factor that eludes experimental control, since the results arrived at by equally competent observers are no more concordant—even nowadays—than they were more than two centuries ago in the times of Dodart and De Halle.

There are, indeed, but few points on which the uniformity of opinion is absolute. It is unanimously said and believed that the crico-thyroid muscles extend the bands; but contrasting with this accord as to their functional significance, we have on the explanation of the accomplished act a sum of information made up of the most conflicting theories, the difficulties residing in the precise determination of the excursions of the cartilages best adapted to bring on and control the adequate attitudes requisite for distinct sonorous tensions.

The current theories thereon may be classed in two main groups:—

1. Those which affirm that the condition *sine quâ non* of the elongation of the bands is the approximation anteriorly of the cricoid and thyroid cartilages, with a corresponding depression of the arytenoid region.

2. Those which assert, on the contrary, that the cartilages are separated or kept apart by the crico-thyroid muscles.

[1] Read in the Laryngological Section of the Ninth International Medical Congress, Washington, 1887.

The second group has only a historical interest, the greatest weight of evidence being in favour of the first opinion, and its supporters dissenting solely as to which is the disturbed cartilage in the accomplishment of the act.

They are subdivided thus :—

a. The cricoid is the fixed point, and the thyroid rotates forwards and downwards. This is the classical widespread theory, and to it are attached the names of Galen, Casserius, Meckel, Müller, Turk, Henle, Hyrtl, Cruveilhier, Quain, Gray, Sappey, Carpenter, Huxley, Todd, Bowman, Schrötter, Heath, Kuss et Duval, Beaunis, Morel et Duval, Mackenzie, Wagner, Jaccoud, Hermann, Dieulafoy, de Meyer, etc.

b. The cricoid is moved on to the thyroid : Magendie, Longet, Cuvier, Lauth, Battaille, Fournié, Jelenffy, Schech, Schmidt, Edwards, Cohen, Elsberg, Stillman, Hooper, etc.

c. Both cartilages are brought together : Vesalius, Merkel, Blache and Beclard.

The crico-thyroid muscle is the active element that has furnished such divergent results through vivisections and experiments on the cadaver ; but all these theories are necessarily more or less defective, inasmuch as they only give us the detached and independent action of a muscular apparatus without full attention to incidental circumstances which modify greatly the ultimate static effects of its contractions. In fact, since Winslow's protest against the Galenic theory and Duchenne's (de Boulogne) brilliant demonstrations, it is a well-established principle in muscular dynamics that, physiologically, no muscle ever exerts its mechanical influence independent of other forces, passive, or actively awakened in associated automatic centres, by the initial purposive impulse. The effects of these forces on their respective subordinate organs, are, in the aggregate and functionally considered as to the end aimed at, correlative to each other ; but, if mechanically studied, they are found to be very often antagonistic. Their ultimate function, then, is the resultant of their combined action entirely opposed at times to the immediate and direct manifestation of the activities of its constituent elements.

In our present case, in no instance do I see that the whole vocal apparatus has been placed in conditions natural enough to bring upon its solid frame certain extrinsic forces, active and passive, of great moment, and which, through the intricate solidarity of the laryngeal structural arrangement, are decomposed and utilized so as to be brought to bear on the cartilaginous support of the vocal bands, in the best possible manner, to render the kinetic energy of the crico-thyroids most effective on the length and resistance of the bands.

The crico-thyroid muscles will approximate the thyroid to the cricoid, or the cricoid to the thyroid, or both to each other, according to the relative fixity afforded to its insertions ; but neither of these results can be in harmony with the demonstrations of the laryngeal mirror and clinical observation, because the experimental basis has not been as exact as it should be.

Ferrein, the first experimenter on the human cadaver, detaching the

larynx with a portion of the trachea, studied thereon the effects of a current of air. J. Muller solidly fixed the human larynx to a board, nailing down the arytenoid and cricoid cartilages, and he succeeded in elevating the pitch of the sound produced by a current of air passing through the glottis, by tilting forward the thyroid through a weight and pulley.

Longet, after sectioning the superior laryngeal nerves in dogs, provoked a hoarseness readily overcome by approximating anteriorly both cartilages. Hooper, in thoroughly etherized dogs, well secured to a dog-holder, stimulated electrically the exposed superior laryngeal nerves without disturbing any muscular attachments. Through a system of levers stuck into the centre of the thyroid and cricoid cartilages and, on proper stimulation, before and after section of the medulla oblongata, he obtained tracings on a smoked revolving cylinder showing that the cricoid was drawn up to the thyroid.

These are the leading data upon which is based our present knowledge of the physiological *rôle* of the crico-thyroid muscles. They teach us that the rotation forward of the thyroid alters the tension of the bands and also the simultaneous approximation of both cartilages to each other. They tell us, likewise, that the direct stimulation of the crico-thyroids displaces the cricoid because it is less solidly fixed than the thyroid, and that, on certain conditions, the least resistance is in the line of its rotation upwards. No other evidence do these experiments convey, and by no means do they contain the proofs that either of these results is exclusively the constant effect of the muscular power under consideration, when associated with the variable and complex circumstances attending normal phonation. In fact, during normal vocalization, the increasing demand of tension of the vocal bands for a series of ascending prime-tones, coincides invariably with the progressive ascent of the whole larynx, carried up from its respiratory position by the powerful supra-hyoid muscles. Consequently, the trachea being put upon the stretch, the tensor muscle is called upon to act with its insertions under the influence of two antagonistic forces unequally distributed on the antero-posterior diameter of the cricoid, against its anterior segment, through the greatest resistance of the anterior portion of the trachea and the unyielding tracheo-cricoid ligament on the one side, in contrast with the elasticity of the posterior tracheal ligament on the other. The immediate result of these factors is a more or less effective separation of the cricoid and thyroid cartilages anteriorly, limited solely in this tendency by the energy of the traction force and the elasticity of the anterior inter-cartilaginous ligament. Now, then, the obliquity of the fibres of the muscle in question is a very unfavourable mechanical disposition for it to overcome resistances thus distributed, and the worst possible conditions, hindering such an evolution of the muscular power, are created by the unsteadiness of the resistance as represented by the crico-thyroid articulations. Under these conditions, the significance of the end-points of the cricoid, as to motility and resistance, are necessarily reversed, and the form changes consequent to the active force being inversely proportional to the resistances acting in opposition to the movement, the effective traction force has to resolve

itself, in this case, in the direction of the crico-thyroid articulations, as representing the initial absolute motility, and not in the line tangential to the arc of rotation of the cartilage. As opposed to these interpretations, there is the general assertion that the movement allowed by the crico-thyroid joints is of a rotatory description, the articular surfaces revolving on their transverse axes. But this limitation is not correct, since the articular surfaces are susceptible of a general gliding motion impressed upon them and directed by the powers acting on their levers, the geometric sections of the opposed surfaces and the lax capsular ligaments with their reinforced antero-inferior fasciculi, permitting and limiting, respectively, the displacement, but not determining it.

My own investigations to determine how the tension of the bands is regulated rest exclusively on clinical observation, dissections, and experiments on the cadaver. Vivisection led me previously to certain misinterpretations. The narrow compass assigned to us on this occasion compels me to omit all technical description.

My leading object has been to determine how the bands are influenced by different positions of the cricoid and thyroid in distinct positions of the larynx, and to ascertain under which circumstances the maximum distensive effect is obtained. I proceeded thus: Fixing the thyroid solidly in its cadaveric position, and acting on the cricoid so as to approach it to the thyroid, it was found difficult to execute the required rotation without a concomitant slipping movement upwards and backwards. To succeed in the attempt, the traction had to be directed forwards and upwards, and then certain results originated, utterly incompatible with the possibility of such a rotation ever presiding by itself over the longitudinal tension of the bands, above all in the respiratory position of the larynx. Thus, the length of the glottis, from its extreme anterior point to the inter-arytenoid region, measured twenty-five mm., before and after the experiment; the width of the glottis was not reduced, and the bands assumed a thick, lax appearance. The arytenoids were invariably depressed three mm. at least.

The cricoid being properly fixed, the uncomplicated rotation of the thyroid downwards yielded similar results. Repeating the previous experiments, but allowing the cartilages to glide over, as it is their natural tendency, forward in the case of the thyroid and backwards with the cricoid, then a certain extension of the bands takes place; but they remain comparatively lax, even after previous co-aptation of the arytenoids.

Now, then, by the gradual elevation of the thyroid to its full capacity, the crico-thyroid space gains five mm. in height over the six and a half that it has when undisturbed; the upper surfaces of a band are depressed four mm., and they become somewhat resilient. The cricoid is less movable. Thus prepared, if we proceed to study the problem under discussion, we learn certain facts of great interest. The cricoid being firmly secured, if we tilt the thyroid forwards and downwards, an actual extension of the bands takes place of one and a half mm. as an average; but their free border is yet lax, they are easily turned over, and they remain so.

Reversing the basis of the experiment, if we maintain the thyroid absolutely immovable, and we act on the cricoid, three things may happen :—

1. The cricoid being rotated strictly upwards as far as possible, then we have—depression of the arytenoid region ; slight elongation of the bands ; a slight diminution of the width of the glottis ; vocal bands thick and lax at their free border.

2. The cricoid is elevated and allowed to slide backwards, then we obtain—elevation of the arytenoid region ; elongation of the bands from twenty-five to twenty-six and a half mm. ; the width of the glottis is greatly reduced ; the bands less thick and lax than in any of the previous cases.

3. The cricoid being acted upon in the direction of the fibres of the crico-thyroid muscles, then it is readily and energetically displaced backwards and upwards ; the glottis is reduced to a mere chink ; the length of the bands increased to twenty-eight mm., the arytenoids are elevated ; the vocal bands become narrow and resilient ; their free border is held in place, and the crico-thyroid space is not lessened in height.

From this inquiry we may conclude that the excursions of the cricoid cartilage are the most effective in results on the modification of the bands, and that they are not invariably the same under all circumstances. That it influences in a twofold and contrasting manner the physical properties of the vocal reed, according to the position of the organ, regulating thus and controlling in association with other factors, the oscillative phonetic antagonism of their two dimensions.

The crico-thyroid muscle, then, is the direct longitudinal tensor when in favourable conditions to retract the cricoid, and it is also a direct factor in the transverse extension. Its participation on the width of the bands is in direct relation to the capability allowed to it in elevating the cricoid by the greater or less depression of the whole larynx, the thyro-arytenoidei contracting and swelling proportionately to furnish the bands with the sonorous tension that they progressively lose as the organ descends, and thus, by the two sets of muscles, a continual process of compensation is kept up. This intimate solidarity between the cricoid and the vocal bands is to be explained by the presence of a fibro-elastic structural arrangement, incompletely described by anatomists, and not duly appreciated functionally by physiologists and laryngologists. I refer to the inferior thyro-arytenoid ligament. The best reputed authors give us six dissimilar descriptions of it. Fournié, Beclard, Huxley, and de Meyer describe it as constituted by the general submucous fibrous investment of the larynx, adherent to the thyroid anteriorly, to the arytenoid posteriorly, and below, to the inferior border of the cricoid (Fournié, Beclard).

Quain, Sappey, Gray, Heath, Bökel, Morel, and Duval speak of it, being the upper free border of the lateral crico-thyroid membrane springing from the upper border of the cricoid according to Sappey, Gray, and Mackenzie, and from the inner edge of the upper border according to Quain. Based upon numerous dissections, and transverse sections of the lateral walls of the larynx, we come to the conclusion that

the ligament in question is not a mere membranous structure. It is a large, thick, fibro-elastic pyramidal body, as shown in the direct photographs which I present, bounded internally by the submucous fibrous investment of the larynx, externally, by a membranous expansion attached to the outer surface of the cricoid cartilage; and below, by the cricoid cartilage itself. The base measures no less than five mm. half way from its anterior to its posterior extremities, and from it spring strong offshoots of fibro-elastic tissue, filling up the space included between the lateral walls, to ascend to the apex of the pyramid, where they terminate intermingled with and capped by the longitudinal thyro-arytenoid fibres. This substructure is both anatomically and physiologically a most integral part of the vocal apparatus, and it represents in man, together with the cricoid cartilage and crico-thyroid muscles, the highest evolutive adaptation of the elements existing in certain lower vertebrates endowed with modulation of voice.

In the tracheo-bronchial syrinx of song-birds we have in its bare simplicity the schema of what is essentially phonogenous in the human larynx. The thyroid and cricoid are represented by the ossified inferior segment of the trachea and upper portion of the bronchi. The vocal bands are constituted by a thick and loose segment of the general fibro-mucous lining membrane, adherent to trachea and bronchi anteriorly and posteriorly. During phonation two sets of distinct perpendicular and oblique tracheo-bronchial muscles double in the mucous membrane and stretch it, elevating the bronchial ring and shifting it backwards under the steady tracheal extremity. This is fundamentally the mechanism of the human larynx, where the vocal bands being furnished with a direct transverse tensor, the kinetic energy of the crico-thyroids is brought to effect distinct form changes by the interchange of the points of absolute motility and resistance through extrinsic forces, regulating the general position of the vocal organ. From the adduced facts and considerations, I am led to attribute to the crico-thyroid muscles an active intervention in both the longitudinal and transverse dimensions of the vocal bands. If the larynx is in the respiratory position, then it draws up the anterior segment of the cricoid, the arytenoid segment is depressed, the free border of the bands relaxed, and thus, indirectly, it co-operates with the thyro-arytenoideus to their transverse tension. If, on the contrary, the larynx is more or less suspended, then its contraction is resolved in a displacement backwards and upwards of the cricoid, the bands are powerfully elongated, the transverse diameter reduced, and it opposes at the free border of the bands, through the thyro-arytenoid ligament, the required resistance to the impinging blast of air. With regard, then, to the vocal bands, I think that Ludwig's nomenclature of the laryngeal cartilages could be advantageously modified. Retaining for the arytenoids the designation of the "cartilages of position," the thyroid would be the "cartilage of suspension," and the cricoid the "cartilage of extension." These interpretations find also a solid support in clinical observations. Elsewhere, I have described, under the head of "Laryngo-Hyoid" paralyses, a hysteroid paralytic dysphonia dependent on insufficient action of the elevators of the larynx

The vocal organ remains more or less in the respiratory position, and the contractions of the crico-thyroids invariably approximating the cricoid up on to the thyroid, the extension of the bands is too limited to pitch properly the note sounded. Under a general phonetic effort, intended for a high prime-tone, the arytenoids are depressed and the free borders of the bands give way under the powerful expiratory current of air, the thyro-arytenoid ligament being relaxed. The traction of the tongue improves the voice, and in some instances it persisted normal for some time afterwards. This phenomenon would be ascribed to a psychical impression modifying favourably the laryngeal disturbed motility, and brought on by the technique necessary for the examination. It is very possible, but the clinical fact is also susceptible of another interpretation. Having restored the voice on certain occasions by the mere traction of the tongue, I thought of a reflex contraction of the paralytic muscles due to the elongation of the antagonistic infra-hyoid muscles, analogous to Westphal's paradoxical contraction, as seen in other regions, and well studied by Charcot and Richet.

This is not the only instance in which the alluded phenomenon can be observed. In cases of functional paralyses of the adductors, O. K. Olliver says, that to restore motility it only seems necessary "to start the machinery," and he advocates, as giving excellent results, phonation during inspiration, and whilst the thyroid is being compressed bilaterally. This procedure is based on Wylies' investigations demonstrating that during inspiration, in these conditions, the cords are forcibly adducted. According to us, the arytenoids being violently rotated inwards the abductors are extended and reflexly the motility of the adductors is restored.

To terminate. The recorded cases of inter-crico-thyroid laryngotomy with a permanent rigid canula in the crico-thyroid space and persistence of modulated voice are absolutely contradictory to the current theories as to the elongation of the bands.

Reclus reports a case of this instance published in the *Gazette Hebdomadaire*, of 1880. He quotes thus on the patient's voice: "Thanks to a valvular canula he speaks with a well-pitched and powerful voice, to such a measure that the existence of an apparatus in the respiratory tract might be ignored."

I myself performed Vicq d'Azyr's laryngotomy on a man for a supra-glottic syphilitic production menacing life. He recovered *ad integrum*, and the emission of voice was not interfered with in the least during high conversation or singing. Vocalization below the fundamental laryngeal sound was impossible.

C. M. Desvernine (Havana, Cuba).

BIBLIOGRAPHY.

Ferrein: Mem. *Acad. de Sc.*, 1741.
Meckel, J. F.: *Traité Général d'Anatomie Comparée*, Paris, 1828.
Blache: Art. *Larynx*, Vol. 17, *Dict. Méd.*, in 30, Paris, 1838.
Müller, J.: *Manuel de Physiologie*, Paris, 1851.
Czermak: *du Laryngoscope*, &c., Paris, 1860.
Longet: *Traité de Physiologie*, Vol. 2, Paris, 1861.
Moure: *Laryngoscopie*, &c., Paris, 1865.

Fournié: *Physiologie de la Voix*, &c., Paris, 1866.
Duchenne: *Physiologie des Mouvements*, Paris, 1867.
Gray: *Anatomy*, fifth edition, Phil., 1870.
Bökel: Art. *Larynx*, Vol. 20, *Dict. Jaccoud*, Paris, 1875.
Sappey: *Anatomie*, Paris, 1876.
Brain, Part 31, October, 1885.
Wylie, J.: *The Edinb. Med. Jour.*, Vol. 12, 1876.
Quain: *Elements of Anatomy*, eighth ed., N.Y., 1877.
Jaccoud: *Pathological Int.*, Paris, 1877.
Hermann: *Elements of Human Physiology*, 2nd ed., London, 1878.
Huxley: *The Anatomy of Vertebrated Animals*, London, 1880.
Dieulafoy: *Man. Pathol. Anat.*, Paris, 1880.
Heath: *Practical Anatomy*, Phil., 1881.
Reclus: *Clinique et Critique Chirurgicale*, Paris, 1884.
Klein et Variot: *Histologie*, Paris, 1885.
Desvernine: *Estudio Fisiologico y Clinico, &c., Disfonias*, Havana, 1885.
Am. Journal of Med. Scs., new series, 1885.
Desvernine: *De la Contraccion Paradojica de Westphal en Laryngo Dinamica. Cronica-Medico-Quirurgica de la Habana*, 1886.
See an abstract of this paper published in the January number of the *Journal of Laryngology*, edited by Mackenzie and Wolfenden.
De Meyer: *Les organes de la Parole. Biblio. Sc. Internationale*, 1885.
Hooper *on the Physiology of the Crico-thyroid*, March, 1884.

NEW INSTRUMENTS AND THERAPEUTICS.

DRAKE AND HASSAM (London).—**Bronchitis Kettle and Food-Warmer Combined.** *Lancet, October* 29, 1887.

A DESCRIPTION of an instrument to serve the double purpose of inhalation, and maintaining the warmth of food. The makers are Messrs. Drake & Hassam, Churton-street, Belgrave-road, Pimlico.

Hunter Mackenzie.

ROTH (Wien).—**New Electric Illumination Apparatus for Rhinoscopy and Laryngoscopy.** *Wiener Med. Presse*, 1887, *No.* 51.

INCANDESCENT lamp fixed on the frontal reflector. **Michael.**

WATSON, SPENCER W. (London).—**A New Galvanic Cautery Instrument, for use especially in the Treatment of Intra-nasal Growths.** *Lancet, October* 1, 1887.

DESCRIPTION and illustration of an instrument for use in the deeper parts of the nose and throat, such as are not easily reached by the loop of the écraseur or snare. **Hunter Mackenzie.**

LANCET, EDITORS OF (London).—**The Dosage of Cocaine.** *Lancet, October* 15, 1887.

THE dose varies in different individuals. No external application weaker than 20 % is satisfactory. Internally the dose varies from ¼ to 1 grain. For hypodermic use a 10 % solution should be employed, not more than 10 minims being used. Cocaine sometimes produces faintness, and even collapse. It rapidly develops a fungus, which renders its solutions dangerous. (This latter may be prevented by the addition of 2 % of boric acid). **Hunter Mackenzie.**

WISE, A. TUCKER (Maloja).—**The Treatment of Pulmonary Consumption at High Altitudes.** *British Medical Journal, November* 5, 1887.

A SHORT article, descriptive of the every-day life of patients at the Maloja, Upper Engadine, with a table of twenty-three cases, all of whom improved, and three apparently completely recovered.

[We would have been pleased if the author, in his table, had shown in each case the behaviour of the tubercle bacilli in high altitudes. We recognize in Case 6 of the series, a young lady in whose treatment we take an active part. Although in this case, as stated by Dr. Wise, "remarkable improvement" has taken place, as indicated both by the general condition and by the local pulmonary signs, tubercle bacilli are still readily found in the sputum in spite of a residence of about two years in the Maloja, and about the same period previously in the Riviera, and in Algiers. It is principally on account of the persistence of these bacilli in the expectoration that this lady is now in the Alps, and we cannot refrain from expressing our opinion that a series of observations indicating the effect of climate upon the organisms, and the average length of residence necessary to reduce their numbers, or cause their complete disappearance, would form a valuable contribution to scientific medicine. We think that this period would be a somewhat prolonged one.]

Hunter Mackenzie.

THE ALPINE CURE: Les Avants, a Winter Resort. *British Medical Journal, November* 5, 1887.

ACCORDING to the author, Les Avants, which is situated about 3,300 feet above the sea level, possesses many advantages over the higher Alpine residences. It is more accessible, and is not trying to weak hearts or the subjects of insomnia. As a resort for nervous cases he considers it unrivalled, and it is pre-eminently suited for those convalescing from acute diseases, and from operations. **Hunter Mackenzie.**

CHÉRON, PAUL.—New Treatment for Whooping-Cough. *Union Médicale, October* 18, 1887.

BIBLIOGRAPHIC review of works which have lately appeared. He divides the medication into:—1st. Antiparasitic: phenic acid in inhalations, salicylic acid, salts of quinine, sulphuric acid. 2nd. Drugs acting on the nasal mucosa: benzoin, tannin, quinine, bismuth, boric acid. 3rd. Drugs causing modification of the mucosa: oxymel scillæ, grindelia robusta, Indian hemp, carbonate of potash, baths of compressed air. 4th. Anæs-

thetics: cocaine, belladonna, drosera, inhalations of ether. It is difficult to choose between these new medicaments, none having been proved satisfactory. The author's opinion inclines to the classical treatment.

Joal.

WIGLESWORTH, ARTHUR (Liverpool).—**Scarlet Fever: Prophylaxis and Treatment.** *Lancet, October* 8, 1887.

CARBOLIC Acid is the remedy employed. Dose (the carbolic acid prescribed is specially prepared for internal use, and is rendered liquid by the addition of 10 per cent. of water): in children from two to six years of age, 3 minims in syrup and water (about an ounce altogether); this must be given every two hours night and day for the first three days, longer if necessary, thereafter gradually diminishing the dose until convalescence is established. In older patients the dose should be 4 minims, and in adults 5 or 6 minims. Eight minims (equal to over 7 grains of pure carbolic acid) is the maximum. The writer lays great stress upon the bi-hourly administration of the drug: "It is in the frequency, as well as in the dose, that safety is found." That the dose is sufficient is indicated by the urine becoming smoky, and in time almost black. In order to effectiveness, the treatment must be commenced *ab initio*.

Regarding the throat, he does not interfere with ulcerated tonsils. He looks upon the extent of ulceration as an indication of the severity of the disease, and regulates the dose of the acid accordingly.

This treatment, in the hands of the author, has proved "an unqualified success," not only as a means of combating the disease, but also as a prophylactic. He has not lost a patient out of nearly 300 cases thus treated.

Hunter Mackenzie.

LEE, SAMUEL (Barking).—**The Treatment of Scarlet Fever.** *Lancet, October* 15, 1887.

A SHORT letter to the Editors confirmatory of the observations of Mr. Wiglesworth, above referred to. **Hunter Mackenzie.**

DIPHTHERIA.

MERCIER.—Diphtheritic Sore Throat: its Cure by Chloral. *Besançon*, 1887.

THE success of the treatment depends not only upon the employment of chloral, but upon its method of administration. Small doses every half-hour should be given, so as to keep the patient continually under its influence. An emetic should first be administered. **Joal.**

BARCLAY, R.—Diphtheria of the Ear. *Weekly Medical Review, November* 12, 1887.

AFTER a careful bibliographical review of the subject the author concludes:—Aural diphtheria has an insidious invasion, usually painless, apt to become chronic and produce widespread destruction, with necrosis

and burrowing into neighbouring parts. Its effects may be manifested in fœtid discharges, deafness, erosion of the Eustachian tube, mastoid perforation, partial or facial paralysis, meningitis, thrombosis, embolism, pyæmia, cerebral abscess, and death. The ear should, therefore, be early and frequently examined in diphtheria. **Wolfenden.**

FALLIS, C. W.—A Severe Case of Diphtheritic Paralysis. *Weekly Med. Review, December* 3, 1887.

THE author was infected through a wound in the finger, and suffered an attack of the disease. Three weeks after its subsidence, impaired vision and paralysis of accommodation followed and diplopia. Numbness of the tongue, paralysis of muscles of deglutition, with regurgitation of fluid through the nose, succeeded. Pulse was rapid (120 in the minute), staggering gait, facial paralysis of the left side, impairment of motion, until the author could neither stand nor walk, followed by such weakness that he could not turn in bed, or even lift the hand to the head, or one limb over another, or feed himself. Sensation was much impaired; the respiratory muscles were not involved, and speech remained. The bowels were paralyzed. Some symptoms became aggravated, while others abated, the first to disappear being those that came on first, the small muscles recovering before the large fleshy ones. The course of the disease from the beginning to the worst stage was about nine weeks, and it remained stationary two weeks. By the fifteenth week the author was well.

Strychnia, iron, and cinchona was the treatment used. Electricity was tried, but without effect. **Wolfenden.**

BAUDNY, W. K.—Papayotin in Diphtheria, especially as to the Treatment of the Local Manifestations. *Weekly Med. Review, December* 10, 1887.

THE author recommends, instead of the five per cent. solution recommended, a concentrated paste, which he finds more reliable. The paste is made by mixing the powder with water, and adding a drop of lactic acid. It is applied with a camel's hair brush, at first every quarter to half-hour. The author claims that, with the solution of the membrane, the general symptoms diminish. **Wolfenden.**

FRASER, G. R. (Wark-on-Tyne).—**Diphtheria Circumscripta, or Sandringham Sore Throat.** *British Medical Journal, November* 5, 1887.

"THE disease is no doubt specific, manifesting itself locally in inflammation of the tonsils, without much enlargement of these organs, the slough appearing, as a rule, first on one side, and, as it is about to separate, the opposite tonsil becomes attacked in the same manner. Or there may be sloughing of one tonsil, and only ulceration of its fellow, albeit of a low erysipelatous type: the inflammation, however, quickly subsides on the formation of the slough. Sloughing of the uvula is no doubt rare, but when the congestion affects it—as it usually does, more or less—and when it reaches a certain stage, there is no reason why this organ should not undergo the same process as the tonsil. I have witnessed two instances

in which it was left permanently misshapen and wasted. The disease is widely prevalent in some Northumbrian villages in the dry, hot months of summer and autumn." Hunter Mackenzie.

O'DWYER, JOSEPH.—Fifty Cases of Croup, in Private Practice, Treated by Intubation of the Larynx, with a Description of the Method, and of the Dangers incident thereto. *Medical Record, October* 10, 1887. (Reprint.)

FROM 1880-1885, during the experimental stage of intubation, the author operated on sixty-five cases of croup (sixty being in the New York Foundling Asylum), and had but nine recoveries, or not quite fourteen per cent. He has never resorted to intubation until suffocation from laryngeal obstruction was impending, as indicated by marked recession of the supraclavicular and episternal regions, restlessness, and absence of respiratory murmur over the lower lobes of the lungs posteriorly. In the twelve cases which recovered the tube was retained on the average, for five days and seven hours. The thirty-eight cases which died lived, on an average, two days and seven hours after intubation, all being desperate cases which would have died without operation. The method of performing intubation is detailed. In cases that progress favourably, the author says the tube should be removed on or about the fifth day. The removal must be regulated by the age of the patient, and it can be dispensed with earlier in cases of slow than of rapid development. If loose membrane exist below the tube, indicated by flapping sound and croupy cough, the tube should be left *in situ*, until the membrane dissolves and disappears. The tube should be removed whenever urgent secondary dyspnœa occurs. Spasmodic dyspnœa often follows removal of the tube, and most frequently when the larynx has been much irritated by repeated attempts at extraction. It usually subsides in an hour, especially if aided by an anodyne. The irritating cough is promptly relieved by re-insertion of the tube. An antispasmodic, about an hour before intended removal, will lessen the difficulty ; or coating the upper part of the canula with cocainized gelatine. The author now uses gelatine medicated with boric acid. The tube must not be coated too thickly, as the gelatine swells, and produces painful dilatation. The author believes that the commonest cause of pneumonia, after both intubation and tracheotomy, is the impairment of the expulsive power of the cough from inability to close the glottis, and consequent retention of secretions in the bronchi, and not entry of extraneous substances through the tube. There is, however, more power to expel secretions through the intubation tube than the tracheotomy canula. The cause of death, after operation, is usually extension of the croupous inflammation to the bronchi, and pneumonia could not be demonstrated without the microscope. Some of the dangers and accidents of intubation are avoidable, and are due to want of previous practice on the cadaver. One such accident is apnœa from prolonged efforts at introduction. False passages may be made, if force is used, through the trachea or œsophagus. Injury may be done to the larynx in removing the tube by passing the extractor outside the tube—the cricoid cartilage has been cut through, and the glottis widened, so that the tube falls into the trachea. A regulating

screw is now adapted to the extractor. Pushing down membrane may occur, coughing out the tube, blocking of the tube with membrane, or adhesion of tenacious secretions when the tube should be removed, cleansed, and cough be excited. If vomiting occur during insertion or extraction of the tube, the operation should be suspended, in order to prevent entry of vomit into the air-passages. **Wolfenden.**

NOSE AND NASO-PHARYNX.

ARVISET. Contribution to the Study of the Erectile Tissue of the Nasal Cavities. *Thèse, Lyons, August,* 1887.

In the mucosa of the nasal cavities there is an erectile tissue, situated on the turbinated bodies and on the septum. The erectile nature of this tissue is proved by its development, capillaries appearing on the points it will afterwards occupy, and assuming a cavernous aspect; by its structure, which shows us it is formed of capillaries covered with an endothelium, and forming a mesh limited by trabeculæ enclosing smooth muscular tissue; and by its physiology, which exhibits the turgescence of this tissue under various excitations. In man this erectile tissue is situated exactly under the epithelium of the mucosa, the net work is superficial, narrow on the surface, but more wide in the deeper parts. There is a close connection between the generative functions and the turgescence of this tissue: it is possible that in animals the tissue is destined to produce erection by reflex action at the period of "rut." Anything which produces congestion or anæmia of the face produces turgescence or the opposite of the pituitary erectile tissue, and such turgescence, if too severe, might cause rupture and epistaxis: it is seen by the rhinoscope that it is especially on the points where this tissue exists which gives rise to epistaxis. Nasal hæmorrhages, whether spontaneous, idiopathic, plethoric or supplementary, are due to the ruptures of the cavernous tissue by reason of increase of tension in the vessels of the head. **Joal.**

WILLIAMS, RICHARD (Liverpool).—**On Ozæna.** *Liverpool Medico-Chirurgical Journal, July,* 1887.

In the course of a short review the author draws attention to the lachrymal obstruction which he has observed as a complication of many of his cases, and considers that it has an important bearing on the question whether or not ozæna is inflammatory in its initial stage. He is of opinion that there must be an extension of inflammation from the nostril into the nasal duct to cause the stenosis. **Maxwell Ross.**

SEILER, C.—Chronic Rhinitis as an Etiological Factor of Acne of the Face. *Weekly Medical Review, October 29,* 1887.

Acne vulgaris and rosacea occur frequently with chronic rhinitis, and especially the atrophic form, and the latter is the exciting cause very

often. In this condition the cavernous tissue of the nose is absent or greatly diminished, and very little or no relief is afforded for the excessive blood-pressure in the capillaries of the skin of the face, and the result will be acne, if the predisposing causes be present. The author has seen the acne disappear with the re-formation of the cavernous tissue. **Wolfenden.**

VILLEDARY.—Nasal Varices and their Treatment. *Thèse, Bordeaux*, 1887.

SO-CALLED spontaneous epistaxes are very rare ; the cause of a flow of blood is generally venous dilatation, which commonly takes place on the septum at the anterior portion of the nasal cavities. These ectasies can only be diagnosed with the help of the rhinoscope, and the noses of patients must always be examined when they are suffering from an epistaxis difficult of explanation. For treatment of nasal varices cauterization with chromic acid or the galvano-cautery is necessary.

Joal.

YSAKYROGLOWS (Smyrna).—**Two Cases of Nasal Polypi.** *Monatschr. für Ohrenheilk., &c.*, 1887, *No.* 10.

(1) Polypus of the septum. (2) Reflex asthma caused by little polypus.

Michael.

GAREL.—Treatment of Nasal Polypi by the Galvanic Loop.

THE eminent specialist of Lyons never operates on nasal polypi with the forceps. He finds the employment of the galvano-caustic handle much preferable to the use of the cold snare. He uses Jacoby's snare of tempered iron wire and Trouvé's pile, with eighteen carbons and twelve zincs. More or less important portions of the tumour are sometimes taken away without causing a drop of blood to flow, but this is not always the case, especially when the pedicle of the tumour is approached, when bleeding is not uncommon ; but the hæmorrhage is much less than with the forceps, or even with the cold snare, above all, when care is taken not to heat the loop too much. After an operation on polypi (and the author has removed a great many, using the galvano-caustic loop), tamponning of the nasal cavities has never been necessary, besides which the chance of recurrence is much less than when other means are used. **Joal.**

MOURE.—Gummous Tumour on a level with the Ala of the Nose. *Société de Laryngologie, October*, 1887.

TERTIARY lesions of the nasal cavities, studied long since as regards ulcerations and necroses, are very little known under the form of gummous tumours. The author, therefore, thinks it necessary to quote a case of gumma observed in a woman aged twenty-eight. The tumour occupied the internal aspect of the left ala of the nose. The doctor, thinking, no doubt, that this purulent growth, ulcerated on the surface, was a malignant tumour, had proposed extirpation. The patient was quickly cured by treatment and local application. Moure added observations on another patient attacked by a sarcoma on the septum, and pointed out the features aiding the diagnoses of these two cases. **Joal.**

JAMES-ISRAEL (Berlin).—**Methods for Replacement of Sunken Noses.** *Langenbeck's Archiv, Bd.* XXXVI,. *Heft* 2.

A MODIFICATION of Konig's method, which, however, cannot be understood without the illustrations which accompany the text. **Michael.**

RAWDON, HENRY G. (Liverpool).—**Congenital Deformity of the Nose with other Defects of the Face.** *Liverpool Medico-Chirurgical Journal, July*, 1887.

DESCRIPTION of a case in which the right nostril appeared to be absent anteriorly. A pendulous fleshy outgrowth, with a truncated free end and a central circular orifice from which mucus escaped, arose from a position internal to the inner canthus where the right half of the "bridge of the nose" ought to have been. A probe passed through the orifice entered a distinct canal or cavity running the entire length of the growth to its attachment where it was arrested. As the mucus coming from this cavity contained bubbles of air, it was supposed that there was a communication with the naso-pharynx. A plastic operation improved the patient's appearance. **Maxwell Ross.**

F.R.C.S.—**Paroxysmal Sneezing.** *British Medical Journal, November* 5, 1887.

IT is recommended that the nose be examined with a speculum, as there may be "spots of congestion that require treatment." Remedies: Vaseline, concentrated spirits of camphor, or tinct. opii, all locally applied.
Hunter Mackenzie.

TORNWALDT.—**The Question of the Bursa Pharyngea.** II. *Deutsch. Med. Wochenschr.*, No. 48, 1877.

A POLEMICAL article in answer to Schwabach's writings on the subject.
Michael.

ZIEM.—**Remarks on the Causes of Enlargements of the Pharyngeal Tonsil.** *Allg. Med. Centralztg.*, Nos. 30, 31, 1887.

SUPPURATION of the nose is caused by scrofula, and this suppuration leads to enlargement of the pharyngeal tonsil. **Michael.**

MOUTH, TONSILS, PHARYNX, &c.

HARKIN, ALEXANDER (Belfast).

NAPIER, LEITH (London).—**Excessive Salivation.** *Lancet, October* 1, 1887.

TWO letters to the editors in reply to a querist for advice in a case of excessive salivation in a lady four months pregnant. Dr. Harkin remarks upon chlorate of potassium being a powerful regulator of the functions of the salivary glands. In this case he considers the irregularity as reflex from ovarian or uterine irritation, and he recommends the application of a small blister (3 in. by 1 in.) over the fourth and fifth dorsal ver-

tebræ. Dr. Napier says that excessive salivation depends on digestive disturbances, or on reflex irritation. He advises the hypodermic injection of sulphate of atropia into the region of the submaxillary glands, from ·01 to ·025 of the remedy being so administered. The simplest plan is to begin with 2 minims of the 4 gr. to the oz. solution. This may gradually be doubled, The addition of a little morphia may help the cure. Pilocarpine has been found useful in 1-12th gr. doses. When the cause is more glandular reflex than gastric, free doses of the bromides are beneficial. Dyspepsia ought to be treated, and attention ought to be given to the diet. Iron should always be given, 4 grs. of the sulphate or tartrate, with an equal quantity of phosphate of lime, vini ferri in drachm doses, thrice daily. In the event of obstinacy, rectal alimentation for a day or two, and pushing the hypodermic use of atropine, will probably succeed, but the strength must be kept up. **Hunter Mackenzie.**

POYET.—Imaginary Ulcerations of the Tongue. *Bulletin Médical, October 9*, 1887.

THE observations related at the Académie de Médecine by Verneuil are by no means rarely met with.

Auto-suggestion is the etiological factor of this condition; and such patients fall under four heads—1. Those afflicted with lingual neuralgia. 2. Those who, seeing on their tongues enlarged papillæ, render them painful by ill-timed manipulations, 3. Those afflicted with hypochondriasis. 4. Those having lingual leucoplasia without ulceration.

The author advises cocaine for lingual neuralgia, abstention from severe treatment of enlarged papillæ, and reassuring the patient; slight punctures with the galvano-cautery in hypochondriacal subjects, and emollients and a strict *régime* in patients with buccal leucoplasia. Moral treatment is necessary before all; and the greater the confidence the patient places in his physician, the quicker will be the cure. **Joal.**

BARTH.—Parenchymatous Tuberculosis of the Tongue. *Société Méd. des Hop., November* 29, 1887.

CASE of a patient, aged thirty-two, with an attack of pulmonary tuberculosis of the second degree, in whom painful nodules were found in the substance of the tongue. Syphilitic treatment had been tried without success: the patient's expectorations contained bacilli, but there were none in the scrapings from the tongue. M. Barth concluded that it was lingual tuberculosis. **Joal.**

ORLOW.—Tuberculosis of the Tongue. *St. Pet. Med. Wochenschr.*, 1887, Nos. 75, 76.

CASE of tuberculous ulcer of the tongue; excision; microscopical research of bacilli; historical and critical remarks. **Michael.**

MANON.—Varices of the Tongue. *Thèse de Bordeaux*, 1887.

VARICES of the tongue are not of rare occurrence; if little known it is because the affection has been described as ranula, erectile tumour, or

angioma. Several causes combine to produce it (heredity, cardiac and pulmonary affections, affections of the throat and larynx, of the mouth, of the nervous system, and sometimes of the vessels of the brain). Varices are generally benign, but are liable to inflammation and bleeding, and apt to cause inconvenience by their size. Treatment should be by cauterization, galvano-cautery, or ablation with curved scissors. **Joal.**

STEPHENS, LOCKHART.—Case of Epithelioma of the Tongue: Removal of Left Half. *Lancet, October* 22, 1887.

THE author recommends a preliminary laryngotomy and plugging of the pharynx, in order to prevent the downward flow of blood.

Hunter Mackenzie.

BARKER, A. E. (London).—**Epithelioma of Tongue and Glands; Removal by Kocher's Method; Patient fed for a Fortnight through a Tube retained in the Wound; Complete Recovery.** *Lancet, October* 15, 1887.

THE nature of this case is sufficiently indicated by the title. The author directs special attention to the method of feeding employed—by means of a rubber tube passed well down the œsophagus, and secured to the right ear. He much prefers this to both rectal and nasal alimentation.

Hunter Mackenzie.

PASTEUR, W. (Mayfair).—**Infantile Paralysis limited to the Bulbar Nuclei, with Permanent Paralysis of Half the Tongue and Face.** *Lancet, October* 29, 1887.

A BOY, aged two years and seven months, when seen by the author, presented the following features:—Strongly built, and robust looking. Complete paralysis of all the branches of the right facial nerve, without any naked-eye evidence of muscular wasting. The protruded tongue deviated markedly to the left; its right half seems a little thinner than the left, but is not wrinkled on the surface. No other affection of muscles or organs. Latterly, the right side of the face became a little wasted.

The illness dated from an attack of "fever" four months previously, which was followed by carpo-pedal contractions, twisting of face, inability to swallow, and unintelligibility of speech. The power of speech and of deglutition gradually returned.

The author remarks upon the singular nature and distribution of the paralysis. He thinks it probable that, as the child was confined to bed for some time, some temporary paralysis of the limbs may have been present and overlooked. The small amount of muscular wasting is also remarkable. **Hunter Mackenzie.**

THORTH, EDGARD.—Stomatitis, Aphthous, Confluent, Benign, and its Treatment. *Journal de Médecine et Chirurgie Pratique, November*, 1887.

MOST authors agree in recognizing two kinds, the discrete and the confluent. The former has been fully described; as to the latter, only a

few modern authors have taken it into consideration at all. A certain number of observations permit Edg. Thorth to prove that aphthous confluent stomatitis is not always a serious and dangerous disease, but can be benign, even with many recurrences. It is not uncommon to see successive aphthous crops which constitute quite an eruptive cycle and last for several weeks. The buccal exanthem is often preceded by prodromata, about which several of the author's patients were not mistaken, and which preceded stomatitis by twenty-four or forty-eight hours. In some cases the disposition becomes irritable, the organs of the senses are attacked with an extraordinary erethism—smell, hearing, and touch are more impressionable; next day there is a sensation of acrid heat in the mouth and back of the throat, and a red flush, and the day after the eruption breaks out in the form of a crop of small yellowish pimples, the size of a pin's head, scattered over the lips, the cheeks (especially at the interline of the upper and lower molars), and on the sides of the tongue. The second day the vesicles increase, the third day they burst, and only small and very red ulcerations can be seen. In intense cases the back of the tongue peels off in large irregular scales, or desquamates entirely, as in scarlatina. This stomatitis is not at all infectious, and during the eruptive phase the general health is good, the temperature normal; there is only a diminution of appetite, and a little inconvenience in deglutition. This affection generally manifests itself under the influence of errors of diet in persons subject to obstinate constipation. The treatment recommended by Thorth is salicylate of soda, which has produced surprising results. Amendment takes place in a few hours and the pain disappears. It should be used in concentrated solutions, or 20 % at the least. It is applied to the buccal and pharyngeal mucosa five or six times a day, principally after meals.

Joal.

BIMAR and LAPEYRE.—Researches on the Veins of the Pharynx. *Académie des Sciences, October* 31, 1887.

THE submucous net-work shows, at a level with the inferior part of the posterior wall of the pharynx, a very remarkable disposition, viz., a true deep or submucous plexus, not described by authors, and only pointed out by Cruveilhier. This plexus has been found on all the cadavers examined; its form is that of an oval disc, with large superior extremity flattened from back to front, and with irregular contours: it does not reach its maximum of development in old people. It is formed by the agglomeration of a number of veins pressed one against the other, and often anastomosing, and it is a dependence of the venous submucous net-work.

Joal.

VERGELY.—Posterior Cephalalgia: Its Relation to Affections of the Pharynx. *Journal de Bordeaux, September*, 1887.

THE author reports eighteen personal observations, from which he deduces the fact that in the course of inflammation of the pharyngo-buccal and naso-pharyngeal mucosa, a pain is felt in the back of the neck, the vicinity of the occipital nerves, the posterior part of the whole occiput, or particularly the occipital prominence the superior occipital ridge extend-

ing towards the crown of the head, the frontal and temporal region, finally, the posterior part of the mastoid process. The pain thus follows the course of the internal occipital nerve. This pain is felt in acute pharyngitis, in sub-acute cases, and in chronic pharyngitis. It is variable in its intensity, sometimes simply producing a feeling of inconvenience and uneasiness, while, at other times, the pain is sharp enough to awake the patient and prevent sleep. This pain may direct itself towards the mastoid apophyses, and manifest itself with such violence, and so great an alteration of the general health, as almost to point to inflammation of the mastoid cells. In other cases it is not spontaneous, but needs pressure to bring it forth.

When the Eustachian tube, the middle ear, or the tympanic membrane is affected, the pain is felt towards the concha, the tragus, and the squamous portion of the temporal; when the inflammation spreads to the nasal cavities and sphenoidal sinuses, the pains are experienced at the root of the nose, the superciliary suborbital regions.

These pains are probably reflex, and the local treatment of the pharyngeal affection generally causes them to disappear. At the same time, in the case of hysterical, alcoholic, and neurasthenic patients it would be better to pursue a general treatment as well. The author concludes by saying that when a doctor is called upon to treat cases where the pain is localized in the occipital region or back of the neck, he ought to examine the pharynx even when the patient does not complain of the throat. A conscientious work, with a complete knowledge of literature, where the names of Fauvel, Elsberg, Beverly Robinson, Zuckerkandl, Hack, Allen, Legal, and Moure are not forgotten. **Joal.**

RICHARDS, J. THEODORE (Birkenhead).—**A Case of Retro-œsophageal Abscess.** *Lancet, October* 1, 1887.

THE patient, aged three years, suffered from Pott's curvature in the upper dorsal region of the spine. The last three months he had been unable to walk without supporting himself by the hands. The child held the head stiffly, inclined to the left side: he complained of pain on any movement of the head, and on pressure over the spinal projection. The breathing was accompanied by a stridulous husky sound, both in inspiration and expiration, and there was a loud, brassy, short cough. The stridor appeared to be partly nasal and partly laryngeal: it was never great, and was almost absent when the child was undisturbed; it was sometimes inspiratory, at other times expiratory in character. The child swallowed both fluids and solids freely and easily. Death occurred on the eighth day after coming under observation, from broncho-pneumonia.

Necropsy.—Lower lobe of left lung consolidated; numerous caseating and calcareous glands around the trachea. Behind the œsophagus, and closely adherent to it, was a soft fluctuating tumour, oval in shape, larger than a horse-chestnut, in front of the vertebral column and connected with it. The situation of the abscess was fully an inch below the level of the larynx; it projected slightly to the left of the vertebræ, and a smaller sac passed from it to the left. The bodies of the seventh cervical and first dorsal vertebræ, which formed the back of the abscess sac, were

almost destroyed, and the front of the bodies of the two following dorsal vertebræ were also carious.

The author remarks upon the case being somewhat rare, from the lowness of the situation of the abscess, and from the absence of dysphagia, although the trachea was sufficiently pressed upon to obstruct the respiration. **Hunter Maekenzie.**

SCOTT, R. J. H. (Bath).—**Malignant Disease of the Œsophagus; Relief by Gastrostomy; Death twenty-eight days after the Stomach was Opened.** *Lancet, October* 8, 1887.

FEMALE aged sixty-one years, with increasing difficulty in deglutition for about a year before admission to hospital. Five months before admission pain commencd behind the larynx and on the left side of the neck; it also passed down the left arm, and frequently prevented sleep. There was a hard tumour behind the larynx, pressing it forwards; it appeared as an oval swelling on each side of the larynx, about two inches in size from above downwards, and five inches across. Pain on palpation, most markedly on left side, on which side also the cervical glands were much enlarged and swollen. On swallowing fluids they were immediately ejected, along with blood-stained mucus. She was frequently attacked with fits of coughing, with the expectoration of a bloody mucus, and at times purulent sputa with a most offensive odour. Urine scanty and concentrated, bowels confined, hunger and thirst. Gastrostomy in two stages was performed, and the patient died of exhaustion in a month thereafter.

Referring to another method of treating these cases (tubage or permanent catheterism) the author thinks that the passage of a tube, however soft, through a cancerous ulcerating growth, must tend to hasten the ulcerating process, whereas gastrostomy does not in any way hasten the end. **Hunter Mackenzie.**

HACKER (Wien).—**On the Influence of Curvations of the Vertebral Column on the Size and Course of the Œsophagus.** *Wiener Med. Wochenschr.*, 1887, *No.* 76.

LATERAL curvations have usually only less influence on the course of the œsophagus, because this does not follow the course of the curvations. In cases of very high skoliosis, if the first curvation is complicated by another compensatory curvation, there is often also a lateral deviation of the œsophagus. This state may become of practical interest, since it will make catheterization of the œsophagus impossible, and also give cause for false diagnosis of a stricture. **Michael.**

LEYDEN and RENVERS.—On Treatment of Carcinomatous Œsophageal Strictures. *Deutsch. Med. Wochenschr.*, 1887, No. 50.

THE treatment of the authors consists in the application of permanent canulas. If the stricture could be passed, and was in the upper part of the œsophagus, a hard rubber gum canula of seven—five ctm. length was

applied and fixed with silk; if the stricture was situated deeper, they applied an elastic canula. In cases of carcinoma the tubes must be worn permanently, but in the case of a traumatic stricture from burning, the canula can be removed if the case is cured. **Michael.**

WRIGHT, G. A. (Manchester).—**Œsophagotomy for the Extraction of an Impacted Tooth-plate.** *Medical Chronicle, December*, 1887.

In his remarks on the case the author considers that probably the safest plan is to operate in all tooth-plate cases when the plate can be reached, but not extracted through the mouth with forceps, *i.e.*, when the plate is above the level of the sternum. If below this and firmly impacted, œsophagotomy will still facilitate extraction by bringing us nearer to the foreign body. The risk of cellulitis is diminished by the method adopted in this case of stitching up the œsophagus and keeping the rest of the wound widely open. **Maxwell Ross.**

McCARTHY, J. (London).—**A Case of Gastrostomy for Œsophageal Obstruction, with Successful Result.** *Lancet, October* 29, 1887.

Record of a case in which the operation was successful not only in itself, but also in regard to the relief afforded by it. Five months after the operation the patent was living in comparative comfort. The nature of the obstruction, which was situated about two inches from the commencement of the œsophagus, is not stated. **Hunter Mackenzie.**

GERSUNG.—Permanent Tube for the Œsophagus. *Wiener Med. Wochenschr.*, 1887, *No.* 73.

In the case of a boy of seven years of age, who had stricture of the œsophagus from swallowing lye, the author introduced a Nelaton catheter split in the upper part. The patient easily supported this method, and swallowed fluids. Ten days later, the author introduced a double tube of gum, which also was well supported. But some days later the boy became feverish, got stenosis of the larynx, and had to be tracheotomized. The œsophageal tube was removed, and the patient could then swallow fluids. He was treated with the tube for some months, and the œsophagus was then cured. The tracheal canula could not be removed. The author has also applied a similar permanent tube in a case of carcinoma of the œsophagus. The stricture was in the upper part of the œsophagus. Œsophagotomy was performed, and part of the tumour removed. For the first few days the tube was introduced through the wound, and then in the same manner as in the other case. Some days later, the patient wished that the tube should be removed, but in a few days she could not again swallow, the tube could not be re-introduced, and a second œsophagotomy became necessary. The patient died some days later. **Michael.**

H. F. S.—Swallowing a Coin. *Lancet, October* 15, 1887.

Short note of the case of a child, aged six, who swallowed a halfpenny, and passed it *per rectum* eight days subsequently. No inconvenience was caused. **Hunter Mackenzie.**

HEMER, J. LANGTON (London)—**Swallowing a Coin** *Lancet, October* 22, 1887.

A SHORT note (*apropos* of the case of "H. F. S." above referred to) of a female child, aged three years, who swallowed two farthings and passed them *per anum*, the one six weeks and the other five months afterwards.

Hunter Mackenzie.

L.R.C.P.—Swallowing a Coin. *Lancet, October* 22, 1887.

A SIMILAR case to preceding. A girl, aged four years, swallowed a halfpenny, and passed it *per anum* nine days afterwards.

Hunter Mackenzie.

J. B.—Swallowing Spectacle Glasses. *Lancet, October* 22, 1887.

A MALE lunatic swallowed both glasses of an ordinary pair of spectacles. They caused no inconvenience, and were passed forty-two hours afterwards.

Hunter Mackenzie.

LARYNX.

RUAULT.—Œdematous Epiglottides. *Société de Laryngologie, October*, 1887.

RUAULT quotes the case of a woman, aged twenty-six, who felt a foreign body—a ball—in the isthmus of the throat. This came on after a chill: she had had attacks before, but of less intensity. No fever, no cough, chest free. On examining the throat, a slight redness was visible on the arch of the palate and pillars of the fauces. The laryngeal surface of the epiglottis was seen to be entirely filled by a round, hemispherical tumour, the surface of which was smooth and shining, the colour transparent pink, traversed by some varicosities. No apparent lesion of the rest of the larynx. On touching it with the finger, the tumour appeared compressible and elastic. Ruault believed it to be a cyst, and punctured it with a laryngeal knife, but only a little serous matter streaked with blood came out. It was an œdematous tumefaction of an inflammatory kind The patient was quickly cured by the use of the galvano-cautery.

Joal.

HERING.—Treatment of Tuberculous Ulcerations of the Larynx. *Acad. de Médecine, October* 29, 1887.

A FURTHER communication on a subject already known, and of which we have treated. By scraping, and the use of lactic acid, the author has obtained twenty-seven cures out of thirty-six cases of tuberculous ulcerations.

Joal.

SCHNITZLER (Wien). — **Treatment of Laryngeal Tuberculosis with Calcaria Phosphorica.** *Internat. Klin. Rundschau*, 1887, *No.* 51.

SEE the report on the Laryngeal Sub-section of the sixtieth meeting of German Naturalists and Physicians, vol. ii., No. 1.

Michael.

RETHI (Wien).—**Treatment of Laryngeal Phthisis with Calcaria Phosphorica.** *Wiener Med. Presse*, 1887.

As kolisotien has had such good results in the treatment of tuberculous diseases of the joints with calcaria phosphorica, the author has tried the same medicament for laryngeal phthisis. In some cases he has applied the medicament by brushing, in others he has armed an œsophageal probe with the calcined gauze and kept the probe some time in the larynx. The results of the treatment were very satisfactory.

Michael.

SCHMIDT, MORITZ (Frankfurt am Rhein). — **Tracheotomy in Laryngeal Phthisis.** *Deutsch. Med. Wochenschr.*, 1887, *No.* 73.

SEE Section of Laryngology and Rhinology, 60th Congress of German Naturalists.

Michael.

FRAENKEL, EUGEN (Hamburg).—**On Syphilis of the Trachea and Thyroid.** *Deutsch. Med. Woch.*, *No.* 48, 1887.

THE patient, forty-one years old, for two years had had cough and hoarseness with the symptoms of an affection of the left pulmonary apex, but without signs of syphilis. He died in a short time, and at the autopsy the trachea was found to be normal in the first four upper rings, but between this and the bifurcation, irregularly-formed ulcerated yellow tubercles and some radiating tendinous cicatrices were found. The bronchus was constricted with similar cicatrices. Both bronchi had entirely lost all elasticity, and the connective tissue surrounding them was infiltrated with gummata, and a similar condition was seen in the thyroid gland. The hoarseness was due to paralysis of the left vocal cord, due to pressure of the gummatous glands on the recurrent nerve. The greatest characteristic of these cases, as Mackenzie says, is stenosis, but, as he has also observed, subjective symptoms are not noticed at the commencement of the disease. In the author's case they were absent during the whole period. This renders the diagnosis very difficult. The author also relates a case of perforation of the trachea and œsophagus by an ulcerating gumma, the subject of which died from pneumonia, caused by inspiration of food. Concerning syphilis of the thyroid, the author remarks that this condition is only seen in combination with visceral syphilis, and no clinical signs have yet been observed.

Michael.

BERGMANN (Riga).—**On Primary Laryngeal Erysipelas.** *St. Petersburg. Med. Wochenschr.* 1887, 50, 51.

THE author reports upon the recently-published cases, and the views put forward relating to laryngeal erysipelas, and relates the following cases: A boy, six years of age, became suddenly feverish and dyspnœic. The laryngoscope showed swelling of the epiglottis and the ary-epiglottic folds. In the anterior part of the neck the skin was red and swollen. Two days later, the erysipelas of the skin spread to the chest and abdomen. The larynx was cured. Three days later the brother of the boy became ill with the same symptoms; but in this case the

swelling in the larynx was so great that tracheotomy (inferior) became necessary. Three days later the swelling in the larynx had disappeared, and the canula could be removed. **Michael.**

ALEXANDER (Breslau).—**Statistical and Casuistical Communications on Typhus Abdominalis.** *Breslauer Arzte Zeitschr*, 1887, *No.* 27.

THE fifth case related by the author is of interest (viz., typhus and perichondritis laryngea, acute laryngeal stenosis, tracheotomy and cure). Four weeks after the onset of the typhus, perichondritis came on suddenly. Two days later tracheotomy was performed. The laryngoscope showed perichondritis of the cricoid cartilage. Four months later the patient was able to leave the hospital in good health, but unable to dispense with the canula. **Michael.**

HUNT, J. M. (Liverpool).—**Case of Laryngeal Polypi.** *Liverpool Medico-Chirurgical Journal, July*, 1887.

Two growths, forming a mass about the size of a pea, filling up the anterior commissure of the vocal cords, and removed in three sittings by means of the laryngeal ecraseur. **Maxwell Ross.**

SCHUCHARDT (Halle a S.) — **External Laryngotomy and its Value in the Treatment of Laryngeal Tumours.** *Volkmann's Klinische Vorträge, No.* 302 *(Boertkopf and Härtel. Leipzig*, 1887.)

THE patient, a woman of fifty-nine years, came under treatment for aphonia and dyspnœa. She had lost her voice suddenly one year before while crying. The laryngoscope showed a globular tumour as large as a nut and filling the glottis. Tracheotomy was performed. After this operation the tumour became smaller, so that it could be observed that it was located under the glottis, but the patient would not allow it to be operated upon. In the year 1887 the patient returned to the clinic on account of increase in size of the tumour. It now filled the whole of the laryngeal cavity and seemed to be a fibroma. Digital examination showed that it consisted of two tumours, of which one was located over the glottis and the other under it, A wire was laid around the tumour, but it could not afterwards be removed. The patient then consented to an operation. Thyrotomy was therefore performed. The tumour consisted of some globular, hard growths seated under the glottis in the mucous membrane, of which a small portion had to be removed. The wire was found in the tumour. Microscopical examination showed that the tumour was a fibroma. Ten days later the patient was cured, and there remained only an air fistula. The author then gives an essay on the removal of laryngeal growths *per vias naturales* and by laryngotomy, with the following conclusions. (A description of the different neoplasms is also given, but nothing new is put forward.)

1. For malignant neoplasms, in most cases only extra-laryngeal methods, such as laryngotomy and partial or total extirpation, can be performed.

2. In benign neoplasms intra-laryngeal methods should generally be applied. The extra-laryngeal method is to be preferred if the tumour is unusually large, or if it has no pedicle, or if it is seated under the glottis or in the laryngeal ventricles. It may also be preferable to extirpate quickly-growing papillomata by extra-laryngeal methods.

3. The so-called partial laryngotomy, viz., section only of the membrana crico-thyroidea, should never be performed.

4. The danger of laryngotomy is very slight if antisepsis is applied, and it does not produce great disturbance of the voice. **Michael.**

TISSIER.—Cancer of the Larynx. *Gaz. des Hôp., November* 19, 1887.

GENERAL review on the pathological anatomy, symptomatology, diagnosis, and general treatment of cancer of the larynx. A very instructive article. **Joal.**

THACHE.—Cancer of the Larynx. *Bulletin Méd., November* 23, 1887.

THE author concludes:—All cancers of the larynx which have invaded the soft parts or the glands are no longer amenable to any but palliative treatment. When the affection is entirely endo-laryngeal, the radical cure can be attempted if the patient is sufficiently robust. Extraction *per vias naturales* is insufficient. It is only justifiable in order to make a histological diagnosis, and it must not be abused for fear of accelerating the progress of the affection. **Joal.**

MONOD.—Cancer of the Larynx. *Académie de Médecine, December* 6, 1887.

MONOD presented, in his name and in that of Ruault, a case of a larynx attacked with cancer, supported by histological evidence. It was the case of a man aged sixty-two. Laryngoscopical examination showed that the tumour was limited to the right vocal cord. No glandular enlargement; general condition excellent. The authors decided to perform thyrotomy, and, if necessary, partial excision. Tracheotomy was previously performed; but the patient died two days afterwards from pneumonia. The histological examination showed that there was a cornifying lobular epithelioma, limited to the ligamentous portion of the cord, and the author thinks that the partial operation which was planned might have effected a cure. **Joal.**

BEALE, E. CLIFFORD (London). **A Case of Lymphoma affecting the Larynx, Eyelid, and Cerebral Membranes.** *Lancet, October* 15, 1887.

THE patient was a female, aged forty-one, who had been subject to enlargement of glands about both sterno-mastoid muscles for about two years. She died rather suddenly about ten months from the date of coming under observation.

Necropsy showed a lymphomatous tumour on the forehead growing from the under surface of the dura mater, and which had eaten its way

completely through the skull. In the neck were several masses of more or less indurated glands : there was no sign of any fresh tonsillar enlargement (the right tonsil had been excised), but the base of the tongue and the left glosso-epiglottic fold were much thickened with lymphomatous material. The epiglottis also was thickened and infiltrated on its laryngeal side, but its free edge was normal. The lymphomatous material was limited to those parts in which adenoid tissue normally exists, and was most abundant in and about the ventricles. The swelling thus formed was divided by deep and irregular sulci, extending in places almost as far back as the cartilage. There was no marked enlargement of lymphatic glands elsewhere, with the exception of two masses about the spleen.

The author remarks upon the singularly abnormal distribution of the adenoid overgrowth, and on the rarity of lymphoma of the interior of the larynx, as also of the eyelids and cerebral membranes. The disease, he thinks, commenced with a chronic affection of the cervical glands, and was very inactive within the larynx. In regard to treatment, the author considers that, in the more slow and chronic cases, removal of the growths, which can be accomplished almost painlessly and bloodlessly, ought to be more in vogue, as tending both towards the duration of life and the diminution of suffering. **Hunter Mackenzie.**

STEVEN, JOHN LINDSAY (Glasgow).—**Cases of Thoracic Aneurism.** *Glasgow Medical Journal, January*, 1888.

ONE of these is of interest from the fact that the complaint began with symptoms of dyspnœa and dysphonia, which set in suddenly within twenty-four hours. The right cord moved normally. The left was midway between the position of adduction and abduction, and on attempted phonation quite fixed and immovable. At the autopsy the œsophagus and trachea were very firmly incorporated with the posterior wall of the aneurismal tumour, and the left recurrent laryngeal nerve also incorporated to such an extent, that on attempting to trace it over the posterior and under surface of the aneurism the internal clots were exposed.

Maxwell Ross.

BARLOW, W. H. (Manchester).—**Laryngismus Stridulus.** *Lancet, October 22*, 1887.

A SHORT note by the writer regarding the administration of cod-liver oil in this complaint, of which he highly approves. The author states that, in the majority of children's cases in which this oil is given, a large proportion passes unchanged through the bowels, and is not merely useless, but positively injurious by its relaxing effect. The true plan is to reduce the dose until the oil is no longer visible in the motions.

(In a subsequent number a correspondent recommends the addition of one or two drops of the tincture of opium in cases where the oil causes diarrhœa.) **Hunter Mackenzie.**

HOLMES, GORDON (London).—**Paralysis of the Abductors of the Vocal Bands.** *Lancet, October 22 and 29*, 1887.

A CLEAR and succinct description of this condition, and of the most recent

views entertained by the author and other observers regarding its semeiology, pathogenesis, diagnosis, and treatment, with a table of cases.

(This paper elicited a correspondence, which had reference principally to certain omissions from the table of cases.) **Hunter Mackenzie.**

LANDGRAF.—A Case of Aphonia Spastica. *Charité Annalen*, XII., *p.* 234, 1887.

A WOMAN of fifty suffered with aphonia some weeks after a pneumonia. A feeling of constriction of the glottis was experienced on speaking, and if speaking efforts were prolonged she became cyanotic. In deep inspiration the glottis had a width of only about eight mm. All treatment by cocaine, &c., was without result. When the patient was narcotized for an operation the voice was clear, and also if she spoke during dreaming. **Michael.**

MÜLLER (Berlin).—**On Paralysis Agitans, in which the Muscles of the Larynx were involved.** *Charité Annalen*, XII., *p.* 267, 1887.

A WOMAN with this affection had a weak and tremulous voice, and could not speak for long in consequence of fatigue of the voice. Laryngoscopically it was found that the vocal cords approached for a short time only during phonation, then separated from each other, and spasmodic contractions of the arytenoid cartilages followed. **Michael.**

DEFONTAINE.—Tracheotomy. *Pratique Médicale, September*, 1887.

AFTER indicating the cases in which this operation may be performed, in speaking of diphtheria, the author said that tracheotomy in croup ought to be proposed to acquit one's conscience, and performed from a sense of duty, but coldly and without enthusiasm. Children suffering from croup should be placed under chloroform, except in cases where death is imminent. The operation should be performed with the bistoury; the thermo-cautery has only hæmostatic properties, and those are insufficient: however slowly it is used it occupies a special assistant, and prevents the work being done quickly. **Joal.**

VANIOPY (Wien).—**A Needle Ten Months in the Larynx.** *Wiener Med. Presse*, 1887, No. 52.

A TAILOR came, December, 1886, to the author with the statement that he had, during his work, swallowed a needle and thread. The thread was removed with the forceps: the needle could not be found, but the patient was relieved. Ten months later he coughed out the needle. **Michael.**

DAUVIN.—Laryngeal Vertigo. *Journ. de Méd. de Paris, August* 7, 1887.

THE author, on three occasions (1877, 1882, 1885) has been suddenly attacked with coughing paroxysms, with titillation in the larynx, followed by a sensation of asphyxia and loss of consciousness, with immediate return to the normal condition. The same phenomena have been observed in two patients, and Dauvin considers all these attacks to be "laryngeal vertigo." They are probably congestive conditions of the cerebral vessels, caused through the coughing attacks. **Joal.**

NECK, &c.

GIBB, WILLIAM F. (Paisley).—**On Scrofulous Neck and its Surgical Treatment, with Illustrative Cases.** *Glasgow Medical Journal, January*, 1888.

THE author prefixes an account of four cases by an essay (to a considerable extent historical) on the relation of scrofula to tuberculosis. He advocates the Allbutt-Teale method of treatment, and where it is insufficient removal by dissection of the affected glands. **Maxwell Ross.**

VIGOUROUX.—On the Treatment and some Peculiarities of Basedow's Disease. *Progrès Médicale, October* 22, 1887.

FOR a long time electricity has been used successfully in treating this affection: the action of the induced current is specially remarkable. The author has never seen the least result from the use of rational medicaments, *e.g.*, bromides, ergotine, or digitalis. Still less does he approve of drugs, such as iodine, arsenic, &c. As to surgical operations, they seem to him very difficult to justify. The author does not seem to know of Hack's work, and the treatment for the destruction of turgid turbinated bodies.

CRAMER (Wiesbaden).—**Contribution to the Study of Struma Maligna.** *Langenbeck's Archiv, Bd.* XXXVI., *Heft* 2.

A COMMUNICATION of three cases. In the first, the patient, forty nine years of age, had noticed a tumour for six years in the front of the neck, which was not painful, and had resulted from traumatism. Eight days before the author saw him the tumour had increased, and pains in the left arm succeeded, with dyspnœa. The affection was diagnosed to be malignant goître, and was operated upon. Four weeks later the patient experienced great pain, and a pulsating tumour was found over the sternum. This was supposed to be an aneurism of the aortic arch. The pains were so great that Langenbeck operated by ligaturing both carotids. The effect, however, only lasted a few days. Ligature of the right subclavian artery was then performed. The patient became cachectic and demented, and died fourteen days after. Autopsy proved the thyroid tumour to have been malignant.

The second case was a patient of thirty-seven years of age, having had a goître for eight years, which had latterly much increased, having now the circumference of a child's head, and an irregularly cartilaginous surface. Injections of iodine produced no effect. She also had hæmorrhages from the mouth. The tumour was situated on the right side of the neck, and reached to the maxilla. A red tumour was found in the mouth, covered with blood, and the teeth of that side had fallen out. Langenbeck operated, ligaturing the carotid, sawing through the jaw, and thus extirpating it. The wound healed, but four months later the patient died from recurrence. An autopsy was not allowed.

The third case was that of a woman of forty-six, in whom a previously-

existing goître had much increased in size within a year. As the patient had very great pain, malignancy was diagnosed. The struma was operated upon. The same day the woman became aphonic from paralysis of the left vocal cord. When the wound had nearly healed, hæmorrhage occurred, which was proved to come from a tracheal tumour. The larynx was then extirpated. Death occurred from recurrence. **Michael.**

ROSENBACH, OTTOMAR.—On Nervous Cough and its Treatment. *Berlin. Klin. Wochenschr.*, 1887, *Nos.* 73, 77.

NERVOUS cough is one in which neither in the lungs nor in the upper parts of the respiratory organs can any affection be found. The patients have had at some time an acute, but slight, affection leading them to cough in a simple manner. The thorax is fixed, the glottis closed, and by contractions of the abdominal muscles a cough without any, or with less, secretion is produced. The treatment must be psychical. The patients must not be allowed to cough, and if they can suppress the irritation, this irritation itself disappears gradually. **Michael.**

FOXWELL, ARTHUR.—Viennese Notes. *Birmingham Medical Review, January* 1888.

CONTAINS an interesting account of Schrötter's clinic. **Maxwell Ross.**

BATUT.—Study of Hygroma of the Thyro-hyoidean Bursa. *Thèse, Bordeaux*, 1887.

THYRO-HYOIDEAN hygroma really exists. The different treatments used heretofore are totally insufficient. Complete extirpation and removal of the bursa is necessary. This extirpation ought to be followed by the complete rest of the region by use of the œsophageal tube and a compressed dressing. **Joal.**

DUFFEY, GEORGE F. (Dublin); **WILKS, SAMUEL** (London).—**Discoloration of the Skin by Nitrate of Silver.** *British Medical Journal, November* 5, 1887.

CASES confirmatory of those reported by Dr. Barclay J. Baron, in which discoloration of the skin followed the swabbing of the throat with nitrate of silver. Dr. Duffey thinks this resulted not so much from absorption by the tonsils or the ulcerations as from the stomach, into which doubtless much of the salt passed. **Hunter Mackenzie.**

STOKES, SIR WILLIAM (Dublin).—**Inaugural Address on Work Done in Surgery, &c.** *British Medical Journal, November* 5, 1887.

IN this excellent address, amongst others referred to is Professor W. H. Porter, the author of a classical work on diseases of the larynx and trachea. Referring to the operation of tracheotomy in diphtheria and croup, which was condemned by Professor Porter, Sir William believes that it not only gives great and immediate temporary relief, but that in a considerable proportion of cases it is distinctly a means of

saving life. Statistics show 26½ per cent. of recoveries after the operation, and the writer believes this would have been higher if the cases had been available for operation at an earlier date. **Hunter Mackenzie.**

SCHEUERLEN (Berlin).—**Etiology of Carcinoma.**

SCHILL (Dresden). — **Bacilli regularly found in Carcinomatous and Sarcomatous Tissue.** *Deutsch. Med. Wochenschr.*, 1887, *No.* 48.

BOTH authors have, independently of each other, found in carcinomatous tumours and in cancer juice, a new bacillus, translucent in the middle and coloured at each end. Scheuerlen succeeded in cultivating it on potatoes, bouillon and agar-agar, and in producing artificial tumours in animals by inoculation. If the discovery is verified it will be of great significance. **Michael.**

ASSOCIATION AND CONGRESS MEETINGS.

Sixtieth Meeting of German Naturalists and Physicians.

September 21.

HEYMANN, P. (Berlin).—*On Variations in the Form of the Septum Narium.* DEVIATIONS of the septum were found in 99 per cent. of all patients. A very frequent cause is traumatism. The author operates with a cutting instrument which excises the thickening. In this manner it is possible to improve nasal respiration in the majority of cases. He has observed four traumatic abscesses of the septum.

BRESGEN agreed that the usual cause of deviations is a traumatism. The deviations are principally in the lower part of the septum, and must be regarded as callous. Concerning the treatment, Bresgen recommends the galvano-caustic destruction of the cartilaginous parts, and the excising of the osseous parts with a chisel.

HOPMANN remarked that the treatment of variations of the septum must vary according to their different situations. He has also seen cases of abscesses and of hæmatomata of the septum. and believes that a great many of them are traumatic, but that others must be regarded as of embryological origin.

GOLDSCHMIDT was quite satisfied with the instruments of Heymann. He had observed a case in a child with meningeal symptoms, caused by necrosis of the nasal bones. He asked Heymann the after-treatment.

LIPPERT believed that nasal deviations are often caused by pressure, and agreed that the left side is more often affected.

ONODI agreed with the views of Hopmann.

HEYMANN'S after-treatment consisted of tamponning the nose with antiseptic gauze. For anæsthetic he employed cocaine in 20 per cent. solution.

GUYE remarked that he had had good results from employing the method of sawing proposed by Bosworth.

GOTTSTEIN believed that traumatic perichondritis caused the deviations.

GOTTSTEIN (Breslau) communicated a case of *Hysterical Dumbness*. He proposed to make a distinction between spastic and paralytic dumbness.

ROSENBERG related a similar case of a nervous lady, who was mute for a year, and was cured in fourteen days by psychical treatment.

HOPMANN related a case of hysterical dumbness caused by massage. A second attack, which could not be cured by any means, disappeared spontaneously during a procession. The people naturally believed it was by a miracle.

HEYMANN mentioned a case of hysterical dumbness caused by railway spine, a condition called by Mendel hysterica traumatica.

SCHMIDT, MORITZ (Frankfort o/M.).—*On Tracheotomy in Laryngeal Phthisis.* THE author referred to seven cases: two of them died, a third is now in a bad state of general health, a fourth, tracheotomized on account of stenosis, is now so much improved that the canula can be removed. Three cases were cured, including the two cases mentioned in Berlin. There has been no recurrence for more than two years. The author defends his opinion that tracheotomy is the best treatment for laryngeal phthisis.

HOPMANN said that he had often seen good results from tracheotomy, but no cure. He also mentioned a case of extirpation of the larynx which was performed for tuberculosis. The patient died three months after the operation of tuberculosis of the lungs. According to E. Fraenkel's case of laryngeal tuberculosis without affection of the lungs (proved by post-mortem examination), he believed that such cases give an indication in favour of extirpation.

MORELLI described a case of primary tubercular laryngeal tumour of the right vocal band. The patient was tracheotomized, and the tumour removed by a papillotome. The canula could then be removed.

HEYMANN mentioned that Pitta was the first who recommended tracheotomy for laryngeal ulcerations.

ROSENBERG (Berlin) exhibited a double speculum for examination of the posterior laryngeal wall. When it is used a very bright light is required, and anæsthesia must be produced by cocaine.

BRESGEN (Frankfurt o/M.) demonstrated a modified Duplay speculum for little children, probes for the examination of the frontal sinus and antrum of Highmore, and probes for application of chromic acid and nasal chisels.

MORELLI (Pesth) demonstrated a nasal funnel of glass ending in an olive-shaped extremity for instillations into the nose. He also showed a posterior porte-tampon, an écraseur, a new papillotome, and a porte-caustique for nitrate of silver, sulphate of copper, and alum.

Meeting, September 23.

HOPMANN (Cöln).—*On Congenital Osseous Occlusions and Stenoses of the Choanæ.*

HE mentioned two original cases, by which the number of published cases is increased to fourteen.

ABERTÜSCHEN (Crefeld).—A case of total osseous occlusion remained without symptoms, but was discovered only when the patient had an acute coryza. After the cure of the coryza there was no need for operative treatment.

KEEMIR (Düsseldorf) observed a case of osseous occlusion of the right side of the nose. He cured it by the chisel and insertion of gum catheter, and later by a silver instrument.

GOTTSTEIN had operated upon such a case with a drill used by dentists, but would not recommend this method.

MORELLI (Pesth) communicated a case of *Suppurative Rhino-laryngo-scleroma.* In both nares were tumours filling the cavities, and all were suppurating.

BETZ (Mainz).—*Therapeutics of Laryngeal Perichondritis.*

THE patient, thirty-eight years old, became suddenly hoarse April 15, 1885, and suffered from pain in the larynx. Five weeks later the author saw the case. There was no cause to suspect syphilis or tuberculosis, so that an idiopathic perichondritis was diagnosed. There was an abscess on the left part of the thyroid cartilage. The laryngoscope showed a swelling of the left part of the larynx. Tracheotomy was performed. As the condition did not improve as was hoped, laryngo-fission was performed September 9, 1886, and the necrotic left arytenoid and part of the cricoid were removed. As the perichondritis also affected the left part of the thyroid, this also was removed. The patient was cured, and the voice is fairly good. The after-treatment consisted of the application of Schroetter's dilating bougies.

BRESGEN.—*On Croupous Membranes in the Nose and Pharynx.*

USUALLY, the eschar caused by the galvano-cautery disappears in a few days, but if the patient catches cold or acute coryza, the wound becomes covered with new pseudo-membranes. The membrane must be removed, and the wound brushed with iodized glycerine.

SCHMIDTHINPEN referred to twelve cases of rhinitis crouposa. In six of these cases there was no syphilis. The author believed that this state, if chronic, can give rise to ozæna.

HERING believed that cases in which such pseudo-membranes follow after galvano-caustic treatment, are infected by smelling bad water. Therefore the author forbids smelling water after the operation.

SCHAECHTER demonstrated the nasal speculum of Jelenffy.

HOPMANN showed a modification for scissors

SCHMIDT concluded the meeting.

SUBSECTION OF OTOLOGY.

September 20, 1887

GUYE (Amsterdam).—*On Aprosexia: The Impossibility of Concentrating the attention on a Subject, caused by Nasal Disorders.*

THE author described aprosexia (προσέχειν) as a functional disorder of the brain, caused by disturbed nasal respiration, from tumours in the naso-pharynx, nasal polypi, &c. A boy, three years old, could not learn three letters of the alphabet in a whole year at school. After removal of adenoid growths he learnt the whole alphabet in one week. Some gymnasts cannot read and write without feeling headache and vertigo. This state is often caused by diminished secretion of lymph of the brain. This aprosexia is one of the most important symptoms of overwork in the schools. The author finds that, according to his experience, it is very often caused by disturbance of nasal respiration, and asserts that children affected in this way should be examined for any disturbance of nasal respiration.

KUHN asked if in such cases diseases of the middle ear should not be of greater importance than those of the nose.

GUYE replied that nasal treatment alone was effective.

HARTMANN agreed with Guye.

ROLLER mentioned cases of irradiating neuralgia due to nasal affections.

FELLER maintained that such affections are often seen at the age of puberty without nasal disorders.

ROHRER said that there is a great difference between these affections described by the author, and the "Hebefreny" of the age of puberty.

Meeting, September 21, 1887.

ROHRER (Zurich).—*Bacteriological Researches in Affections of the Ear and the Retro-nasal Cavity.*

THE combination between diseases of the middle ear and the retro-nasal fossa has

hitherto escaped the notice of those who have made researches on the subject. He has found eight different micro-organisms in the pus of the middle ear and in the secretions of ozæna.

HARTMANN, A. (Berlin).—*Contribution to the Treatment of Retro-pharyngeal Tumours.*

THE author destroys these tumours with Pacquelin's thermo-cautery introduced through the nose. To prevent burning, he introduces the instrument through a Zaufal's tube, which is impacted in wet cotton. The operation can be completed with electrolysis, with the galvano-caustic wire, or with the galvano-cautery.

GOTTSTEIN stated that he also has applied the thermo-cautery with good results.

HARTMANN, A. (Berlin).—*On the Removal of Foreign Bodies from the Nose.*

THE best instrument for this purpose is the spoon-probe, which can be used in nearly all cases.

GUYE agreed with Hartmann, but believed that his instrument (a forceps combined with two spoons) was the best for this purpose.

SUBSECTION OF SURGERY.

Meeting, September 21, 1887.

TUSTI (Vostein).—*Demonstration of a Patient with doubtful Tumour of the Neck.*

THE author showed a patient with struma maligna, which could not be removed without danger of a recurrence.

SCHUCHARDT (Halle an d. S.).—*Laryngo-fissure for a large Fibroma of the Larynx.*

A TRILOBED tumour, the retro-pharyngeal removal of which was not possible. Laryngo-fissure was performed, and a cure effected. **Michael.**

Ninth International Medical Congress.

SECTION IN LARYNGOLOGY.

Nasal Fibromata. By Dr. W. E. CASSELBERRY (Chicago).

UNDER this title are included only neoplasms of a purely fibrous or predominating fibrous structure, which originate in the nasal fossæ, anterior to the naso-pharynx. Tumours in this situation are prone to assume a compound type, *e.g.*, the fibro-myxomata and the fibro-sarcomata. The scope of this paper will not permit of consideration of these, notwithstanding their intimate relationship to the fibromata. Likewise of fibromata which originate in the neighbouring sinuses, and which involve the nose only secondarily, must such meagre mention suffice as is essential to the elucidation of the nasal growths proper.

Current literature has contained numerous reports of cases of *naso-pharyngeal* fibromata, but fibromata originating primarily in the nose itself are comparatively rare.

The *Internationales Centralblatt für Laryngologie, Rhinologie, etc.*, does not contain a report of a single case; none are included in 265 cases of nasal neoplasms reported by Hopmann and Schmiegelow; yet their occasional occurrence has been recognized from the time of Hippocrates. Mackenzie has reported a single case of his own, and two others probably fibromata, and remarks in this connection:—"Though fibrous polypus of

the naso-pharynx is not unfrequently met with, this form of tumour extremely seldom originates in the nose itself, the only case, as far as I am aware, in which such a growth has been proved to exist being one of my own."

[The bibliography of its subject is next briefly considered.]

Growths in the nose and naso-pharynx, in a measure, correspond in type to the structural elements of the tissues from which they originate. The fibrous layer of the mucosa has been shown by Panas, cited by Mackenzie, to be especially abundant in the naso-pharynx, hence the frequency of naso-pharyngeal fibromata, while in the anterior nares the superficial mucous layer predominates, and hence the more common occurrence in this location of the myxomata. Around the posterior nares the membrane presents a transitional form, and growths in this situation are prone to assume a corresponding fibro-mucous type.

This observation, supported by others, affords a reasonable explanation of the comparative infrequency of true nasal fibromata.

Nélaton, cited by P. Koch, has advanced the opinion that fibrous polyps of the nose are never of a primary nature, that they always proceed from neighbouring sinuses ; but in Gerdy's case, on *post-mortem examination*, the point of attachment was found to be the vault of the left nasal fossa.

Fibromata may arise from any part of the nasal cavities. The roof, especially towards its posterior part, is the favourite site ; but the turbinated bodies, the cribriform plate of the ethmoid bone, the septum and the floor of the nose, may furnish points of origin.

The etiological factors in their development are not definitely known, but a local irritation from traumatism, or even a perversion of the chronic hypertrophic inflammatory process, may serve to excite a hyperplasia of the fibrous elements. Both sexes, and all ages, seem equally liable, differing in this respect from naso-pharyngeal fibromata.

The duration of development averages from one to two years.

The early symptoms are those of a catarrhal nature, followed by obstruction and distension of the fossa. The nasal bones are rent asunder and the neighbouring cavities encroached upon, causing the hideous deformity known as "frog-face."

A probable diagnosis, *in situ*, is not difficult. It is not multiple, bu may be lobulated ; of dark red colour, broad base, non-translucent, and firm and resistant to the probe. The microscope is the only means of positive diagnosis, especially from fibro-sarcoma, sarcoma, etc.

They present the ordinary pathological characters of fibromata : microscopically, firm, dense, and whitish, varying to a softer consistence and a darker colour, and enveloped in a smooth fibrous capsule.

The fibres are grouped in bundles, or are simply closely interlaced. There are a few vessels, and sometimes a very limited number of round or spindle-shaped cells.

Nasal fibroma tends to degenerate into sarcoma, and to recur after removal, although if thoroughly extirpated and the base cauterized to the bone the prognosis should be good. Necrosis of a part of the ethmoid bone may co-exist.

I have tabulated and appended the records of seven cases, including one of my own, which is published for the first time.

Abstract of Case.—Mrs. R., aged forty, had a myxoma removed ten years ago. Five years since, she again noticed symptoms of obstruction, etc. A year later she submitted to operation by the forceps. A few small pieces only were removed, and no relief was afforded. The hæmorrhage was severe both during and after the operation. In February, 1886, she came under the observation of Dr. Franklin Coleman. The fossa anteriorly was filled by a firm elastic tumour, and there was commencing "frog-face," but no involvement of the antrum or orbit. On February 23rd (?), 1886, Drs. Coleman and Gilmore slit up the lower portion of the tumour with the galvano-cautery knife-electrode, and extracted about one-half of it by forceps.

Through the courtesy of Dr. Coleman the case was then referred to me.

Status Præsens, March 4th, 1886.—The left nasal fossa above the line of the inferior turbinated body is filled by a firm, elastic, irregularly lobulated neoplasm. The septum narium, anteriorly, is deviated by pressure far to the right. The naso-pharynx is normal, only a faint outline of the tumour, located well forward, being visible.

First Operation, March 10th, 1886.—Local anæsthesia by cocaine. I employed Flemming's galvano-cautery écraseur, substituting steel wire for the platinum. Platinum wire is devoid of resiliency, a property which enables the écraseur loop of steel to retain or regain its contour after contact. The steel loop offers resistance to tissue against which it is pressed, thus facilitating envelopment of the part. I would catch in the écraseur the most easily enveloped lobule or corner of the growth, connect the battery, and sever without pain or hæmorrhage a cubic centimetre or more of the growth. Three or four such pieces would be removed at a sitting. When necessary, a preliminary incision was made into the substance of the tumour with the knife-electrode, in order to prepare a place for the wire.

The operations were repeated weekly. No inconvenience was occasioned by the treatment at any time. The primary attachments extended along the horizontal plate of the ethmoid bone backward to the anterior perpendicular surface of the body of the sphenoid. The base was cauterized to the bone, a small portion at a time, by means of the galvano-cautery point, knife, or moxa-electrode. At the end of six months the neoplasm seemed thoroughly eradicated, but at the end of nine months a recurrence in the form of a tumour the size of a French bean was noticed and destroyed. It probably developed from a point of secondary attachment which had escaped cauterization. At the end of fourteen months the patient remains well. Microscopic examination demonstrated the tumour to be a fibroma.

Treatment.—Of the cases appended, in No. 1 attempts at removal by ligature and forceps failed, and were followed by an attempt to cut through the base of the polypus with a bistoury, which resulted in death from hæmorrhage. The treatment in case No. 2 is not stated In case No. 3 the tumour projected posteriorly, and was removed by forceps introduced through the naso-pharynx. In three cases, Nos. 4, 5, and 7, external operations were performed to give access to the tumour; in No. 4 a crucial incision was made over the left side of the nose, and the nasal bones were lifted out; in No. 5 the nasal columna and septum were divided, and the nose turned up; in No. 7 a median incision was

made through the bridge of the nose. In case No. 6 (possibly fibro-myxoma) the tumour was successfully removed piecemeal in fifteen sittings by a cold wire snare.

The advantages of the intra-nasal galvano-cautery method, as detailed in the case of Mrs. R., are sufficiently obvious. It was the one means which rendered avoidable a formidable external operation and facial disfigurement. It will usually be found impracticable to encircle the entire tumour and remove it *in toto* at one sitting, on account of the impaction of the mass into the inequalities of the nasal fossa and the formation of adhesions. Moreover, the slower method of removal, piece by piece, offers the advantage of greater deliberation and greater precision.

Caution must be observed in the use of this remedy, and it must not be supposed that all cases are susceptible of its application.

W. E. Casselberry.

A New Therapeutic Agent in the Treatment of Phthisis Pulmonalis. By Dr. JNO. EGE (Reading, Pa., U.S.)

I WISH to call your attention to a therapeutic agent for the treatment pulmonary phthisis, the benefit of which I can demonstrate with the microscope. Before trying this treatment, I would ask that a positive diagnosis of tubercle bacilli be made. Many physicians believe that tubercle bacilli are not the cause but the result of consumption, but all admit that there is no phthisis pulmonalis without bacillus tuberculosis, and allow that if we can get rid of the bacilli the result will be a cure. I will leave you to judge whether or no a cure has been effected by any of the old methods after the bacilli have been found by the microscope. For the last ten months I have successfully treated phthisis by an inhalation of micro-organisms in the following way, which is a modification of Cantani's treatment :—

To the white of one egg I add six to eight ounces of water, and mix, then let it stand in a room, temperature 60° to 100° Fahrenheit. The jar or other vessel containing the albuminous mixture should be covered, but not so tightly that air cannot enter it ; the cover is to exclude dust and insects. The mixture should stand from three to eight days, to give it a penetrating disagreeable odour, the time depending on the temperature ; and it must be strained through a fine wire strainer before using. The patient inhales the mixture from a common atomizer, and uses from half to one ounce at a time, two or three times a day. The tube of the atomizer is placed in the mouth, and the deepest possible inspiration taken while the ball of the atomizer is pressed. At first the patient should be cautious not to swallow the drippings from the spray, as it might produce vomiting. I make two *cultures*, about five days apart, so that when the first one gets too strong the second may be used. The mixture is apt to get too odorous in from two to four weeks. After inhaling the mixture from two to five days the sputum is much thinner and more easily expectorated, the quantity is greater, and the bacilli much increased in numbers, sometimes hundreds of times more than at the beginning.

I have used this method with twenty-nine patients. In one case the cough did not loosen until three months had elapsed, because the patient had hepatization of the lower lobe of the left lung ; but after three months

the hepatization disappeared, and free respiration was restored, the cough was easier, hectic fever and night-sweats disappeared, and at the end of four months the patient had gained fifteen pounds in weight. Of the twenty-nine patients, two died, one in eight days, the other in four weeks. I used the inhalation only four days on each, finding that they were too far gone with consumption of the bowels, as well as of the lungs. With the other twenty-six patients I had splendid results ; some had a history of inheritance. I examined the sputum of each patient several times before commencing the treatment, and found the tubercle bacilli each time.

My first patient, A——, had syphilis, followed by phthisis florida. He expectorated about two quarts in twenty-four hours, was thirty-five years of age, and had a bad family history. His brother died of phthisis at thirty-five years of age, a sister and his mother died of the same disease, and an uncle is suffering from it now. This patient, A——, had night-sweats and hectic fever, tight cough, until sometimes vomiting followed a coughing spell. He was sometimes kept awake all night by the incessant coughing. His morning sputum showed eight to fifteen bacilli in each field of a one-seventh inch objective and No. 3 ocular (Leitz, Wetzlar). The cough commenced to get better within three days. The bacilli increased in numbers, and the hectic fever and night-sweats disappeared in three weeks' time. After two months he returned to his work as an office clerk. During the last four months the bacilli nearly disappeared ; only one or two, and sometimes none, could be found in a specimen. He gained twenty pounds in weight in two months.

Of the other twenty-six there were four from whom I could find no bacilli, and I count them cured.

The remaining patients are all improving, and I predict for them slow but sure cures. In some cases it takes from two to six months before the microscope shows a decrease in the number of bacilli. The microbes in the inhalation are not possessed of a pathological power, and cannot live in the tissues of the living human or animal subject. They do not kill the bacilli tuberculosis, but drive them out of the lung. The question now is, How do they drive them out ? Is it due to the irritation of the lung, which produces more and easier expectoration ? or because they are inimical bodies, or to the form of ptomaines ? or to the penetrating odour of H_2S ? through softening and liquefying the sputum ? cleaning out the breeding nests. *Septic symptoms never occurred yet under my observation.*

The microscopical examination of this inhaling mixture shows bacteria termo, bacillus subtilis, and others ; on getting too old it shows many micrococci which form chains, which we do not wish inhaled. I like my patients to get plenty of fresh air, deep inhalation of good air, high mountain air if possible ; easily digested albuminous nutrition, such as meat juice, blood, milk, and soft-boiled eggs, and good red wine one hour after each meal. If the lung is too much affected, and the body suffers from loss of oxygen, oxygen inhalations will be indicated in addition to the above. Sleep with open windows, but not in a draught ; in bed, have the head low and the feet higher than the chest, so that the blood shall flow to the anæmic lung ; this will often relieve night-cough, and produce refreshing sleep.

After a year's trial, I now have six patients free from tubercle bacilli and in very good condition. In laryngeal phthisis I have had no chance of trying it yet. Simple as this method is, yet from time to time sputum must be examined, and, if no tubercle bacilli are found, the inhalation should only be used for a few weeks or more. In one case I stopped at once, because the patient looked sick, with a specific disease. Two months after I examined the sputum, and found the tubercle bacilli again; so I recommended inhalation added to the medical treatment.

By some patients continuous inhalation is necessary from five to eight and even more months. If the disease is at the apex of the lung, I found that the cure is quicker than when it is at the lower part of the lung.

J. Ege.

Sixth International Congress for Hygiene and Demiography in Vienna.

Meeting, October 2, 1887.

TEISSIER (Lyons).—*On Propagation of Diphtheria.*

THE author has observed in three cases a propagation of diphtheria by birds. He has further stated that the diphtheria of hens is the same as that of men. He therefore recommends that the excretions of those birds should be destroyed.

LONGUET (Paris) has observed that diphtheria is much more common in cavalry than in foot soldiers—that the disease is propagated by the excretions of the horses.

COËN (Vienna).—*By what Methods can the Propagation of Affections of the Speech be Prevented?*

STUTTERING and stammering children should not visit public schools.

Michael.

French Association for the Advancement of Science.

Congress of Toulouse. 16th Session, 1887. (Continued.)

MASSE.—*Anatomy of the Subglottic Region of the Larynx.*

THE author draws attention to the variations of form and capacity of this region in its upper three-fourths. The inferior one-fourth is relatively firmly fixed, but the variable portion of this region has a form alternating between a cylinder and a kind of cone flattened transversely at its summit. It is useful to bear this in mind from a surgical point of view, for the reason that a canula designed for the trachea could not be applied to this region.

ARNOZAN (Bordeaux).—*The Relation between Cutaneous Affections of the Nose and Deeper Affections of the Nasal Fossæ.*

THE author relates three cases. (1) A lady of thirty years of age, with chronic coryza of four years' duration, had observed her nose redden, at first intermittently, afterwards continuously, for a year. An eruption of pustules of acne has now resulted. (2) A lady, with long-standing inflammation of the naso-pharynx, found her nose redden with great facility, and she experiences a painful sensation of heat. Every time the naso-pharyngeal inflammation is exaggerated, the redness and heat of the nose are increased. (3) A young girl, with puffed and tumefied nose, covered with pustules and riddled with comedones, had an abundant and fœtid nasal secretion. Irrigation of the naso-pharynx diminished the volume of the nose and ameliorated the condition. These three interesting facts support the theory of nasal reflex

neuroses, and are vaso-motor affections of nasal origin. Hack, in his important work, has cited similar cases.

BERNHEIM.—*Lingual Monohemiplegia with Cortical Localization.*

A YOUNG girl of twenty-three years of age presented an isolated lingual hemiplegia. At the autopsy a hæmorrhagic clot was found, of five to six millimetres in diameter, on the inferior edge of the inferior extremity of the pre-frontal convolution, six millimetres from the fissure separating it from the third frontal convolution. It would seem, therefore, that at the lowest extremity of the ascending frontal convolution there exists a special centre, or hypoglossal cortical centre.

ARNOZAN and FERRÉ.—*Note on the Suspension of the Glycogenic Function of the Liver in the Rabbit by Rectal Injections of Sulphuretted Hydrogen Gas.*

THE fundamental principle of Bergeon's method of treatment of phthisis is that the gas absorbed by the intestine is eliminated by the lung, and can therefore act upon pulmonary tubercles without impregnating the organism; but four organs at least must be subject to the deleterious effects of the gas, viz., the lungs, the intestines, the heart, and the liver. Three rabbits in which injections of sulphuretted hydrogen were administered, died—two rapidly, the other with progressive emaciation. In all three the hepatic tissue was found to be absolutely deprived of sugar. The gaseous injections had abolished the glycogenic function, showing an important effect thus produced upon the hepatic tissue. A certain caution should therefore be used in the therapeutic application of this method. The authors continue their experiments, the results of which will be made known.

BORIES.—*Blennorrhagic Œdema of the Glottis.*

THE patient was a young woman, suffering from blennorrhagic vaginitis, who developed successively blennorrhagic endometritis, with peritonitis, multiple arthritis, and œdema glottidis. Since there was neither rheumatism, albuminuria, nor chill, the author has no hesitation in referring the glottic condition to the blennorrhagia. **Joal.**

REPORTS OF SOCIETIES.

Surgical Society of Paris.

October 12, 1887.

Cyst of the Superior Maxilla opened in the Sinus; Termination in Catarrh of this Cavity. Observation communicated by M. BAUZON *and read by* M. MAGITOT.

A MAN of thirty-five perceived a hard progressive tumour, with deep fluctuation, and seated on the cheek. Some painful stumps of teeth were extracted, and a slightly purulent and fœtid liquor flowed from the alveolus. The sinus was opened and disinfected with iodoform, a drainage-tube being left *in situ*. Most authors explain the origin of maxillary cysts by (1) inflammation of the alveolar periosteum; (2) formation of a periosteal cyst; (3) rupture into the sinus; (4) consecutive catarrh. Others (Verneuil, Reclus, Kirmisson, Malassez, Albarron) maintain that these cysts arise from congenital masses of epithelium, remnants of the gubernaculum dentis. This theory is not supported by any clinical facts. The cysts always arise from the same point, viz., the summit

of the root of a tooth. The rational treatment consists in extirpation of the diseased remnants of the tooth. If the cyst has broken into the sinus it will be necessary to disinfect it, and to open it by one of four procedures—(1) through the nose; (2) through the mouth, by Desault's method; (3) by the alveolus, which is the simplest; (4) by trephining the arch of the palate, according to Bertrand and Boch's plan,—but this is not usually done. Systematic drainage is the important indication.

DEPRÈS did not believe in the possibility of obtaining a complete closure of the sinus which has suppurated. The trial of such a method is dangerous.

MAGITOT thought that when the abscess was recent one might hope for spontaneous obliteration, but old catarrhs could not support efforts at obliteration.

October 19, 1887.

Periosteal Cysts of the Jaws.—KIRMISSON refers to Magitot's remarks at the last meeting and mentions two theories:—1. Magitot's periosteal theory; 2. Malassez' theory, which may be termed the theory of paradentary epithelial remains. Magitot said at the last meeting that he considered the cyst wall to be formed by a remnant of the follicular wall along with its epithelium. This was an idea advanced by him at the Society of Biology. In his memoir in the Archives of Medicine, 1872-1873, he said:—A layer of spherical or polyhedral epithelium is formed on the surface of the cyst wall, sometimes simple, sometimes stratified, showing now and then villous projections which float in the liquid. This formation takes place by direct genesis." Now the generation of anatomical elements at the expense of a blastema is no longer admitted in histology, and the origin of epithelium from connective tissue is no longer admitted. In the pathogeny of cancer, for instance, Virchow's theory is no longer held, and the great majority of anatomists and surgeons hold the origin of cancerous cells to be an alteration in the pre-existent epithelium. It is not possible then to regard the epithelium lining the cyst wall as originating from the fibrous tissue of the periosteum. Malassez has proved that there is no dental periosteum analogous to that found in the osseous tissue, but only a fibrous tissue, the fibres of which run below and inside the alveolar walls towards the root of the tooth. Taken collectively, this fibrous tissue deserves the name of alveolar-dentary ligament. Numerous groups of epithelium cells are interposed in the thickness of this ligament, to which Malassez has given the name of paradentary epithelial débris, and which he makes the starting-point of the cysts of the roots or dental alveoli. Sometimes when a tooth is extracted a small cystic bag is drawn with it quite intact. This is easily understood by following Malassez' interpretation. Fungous growths develop on a level with the top of the root, and are pierced by the paradentary epithelium pushing a germ into their midst. From that proceeds the formation of an independent cyst of the alveolar coat, which can be extracted whole. To sum up, whilst allowing the importance of Magitot's work on this subject, and adopting his clinical views with regard to the relations existing between alveolo-dentary cysts and diseases of the root of the dentary pulp, it would seem that his pathogenic explanation cannot be maintained. Kirmisson considers Verneuil to have been the first to give the true pathogeny of this species of cyst, and mentions that Verneuil's views received startling confirmation from Malassez' late anatomico-pathological researches.

RECLUS believed himself to have been the first to publish, in 1869, the paradentary theory. He showed Malassez a tooth extracted by mistake. It appeared sound and free from caries, but had, nevertheless, attached to the root, a cyst full of fatty matter.

MAGITOT replied to Kirmisson's objections. He explained the presence of

the cystic epithelium thus :—In the periosteum or alveolo-dentary ligament traces of dentary follicle are to be found, and more epithelial elements than are to be found in M. Malassez' collection, though they have been previously described by Robin. Robin attempted to prove that the alveolo-dentary periosteum differs from the periosteum of the bones by the presence in the former of the epithelium. The cysts in questions are always located at the top of the root. We note therefore, that the spot always affected is precisely where pathological secretions raise up the ligamentary tissues. The liquid is not always cystic, but often purulent : this depends on the intensity of the inflammation.

These cysts very often develop on sound teeth exempt from caries, and break at the time of the extraction of the tooth.

Small cysts with thicker coats alone remain intact.

KIRMISSON called Magitot's attention to the fact that no analogy exists between serous and mucous epithelium.

Meeting, October 26, 1887.

A letter was read by the Secretary from RÉNAUT (of Lyons), referring to the discussion on cysts of the jaw. He wrote that he admitted the mesodermic origin of the epithelium, but called attention to the fact that the general type of epithelium developed by the mesoderm is the endothelial. True epithelium formed from mesoderm is very rare. Such cases may be reduced to the epithelia of the kidneys, ovary, and testicle. He concluded, that, after reading all Malassez' publications, and examining almost all his preparations, he entirely agreed with him. **Joal.**

Academy of Medicine of Paris.

October 18, 1887.

On Glossodynia. By MAGITOT.

UNDER this term are included glossalgia, muscular rheumatism of the tongue, lingual neuralgia, and imaginary ulcerations (as described by Verneuil). Medicine is not so poor in relation of cases of this kind as one might think—see, for example, the article "Glossalgia," of the Dictionary in sixty volumes, the work of Halliday (1832), and the observation of Dr. Neffe (1845). Essential glossodynia, without any appreciable lesion of the tissues, is independent of any traumautic, anterior, or coincident organic affection. It is characterized by pain, and can comprise two distinct forms, viz., rheumatic and neuralgic. In the former, pain affects the whole muscular tissue, without affecting any muscle singly : movement increases the pain, which has the ordinary characters of rheumatism. The neuralgic form is characterized by spontaneous and intermittent pain, not increased by movement, and occupying a single branch, or two symmetrical branches (Verneuil). Arthritism is the cause, and is nearly related to various forms of neuropathy. General paralysis and hypochondriasis are rather the sequel of the painful affection. The arthritic condition should be combated, and cocaine or the galvano-cautery be applied locally. **Joal.**

The Medical Society of Warsaw, 1887.

PRZEWÓSKI.—*Demonstration of Pathological Specimens of Tracheitis and Syphilitic Laryngo-Tracheitis* (from the Collection of the Museum of the University of Warsaw).

ALL these specimens had belonged to young people, in whom the clinical features had, during life, resembled those described by Sokotowski (*vide* p. 25). The appearance of the specimens was in all cases the same, viz., ulcerations, various

forms of cicatrices, hypertrophy of lymphatic glands involving the recurrent nerves. In one case the interior of the trachea resembled the interior of a heart, or a contracted urinary bladder. Przewóski has not had the opportunity of seeing the pathological process at its commencement, an opportunity which, of course, coul only be afforded exceptionally by observations upon the bodies of patients dyin from some other causes.

Const. Karwowski

Berlin Medical Society.

Meeting, November 16, 1887.

GERHARDT demonstrated a specimen of *Carcinoma of the Trachea.* The patient was thirty-eight years old, and for two years had had dyspnœa and hæmoptysis. There was some thickening in the fossa jugularis, and the laryngoscope revealed under the fifth tracheal ring a reddish tumour, which caused stenosis. Anti-syphilitic treatment was adopted without avail, and the patient died in a few days.

HAHN related his results in *Extirpation of the Larynx*, and gave a *Demonstration of Specimens.* He has performed fifteen operations. One of his patients has had no recurrence after seven years. Thirteen have died. One patient operated on a year ago has a keloid on the tracheal fistula (? recurrence). He also exhibited a sponge canula for tamponning the trachea during the operation (wrongly called Hahn's canula, but first described three years ago by Michael). Hahn believes that only scirrhus cancers should be operated upon, and soft ulcerating tumours should be left untouched.

Meeting, November 30, 1887.

JULIUS WOLF related a case of *Extirpation of the Thyroid Gland for Struma*, a very difficult case, in which Wölfler's operation was performed with very good result.

KRAKAUER related a case of *Stoerk's Blennorrhœa* (the case was shown). The patient, a woman of thirty-six, had been frequently hoarse, but more so for three weeks. The mucous membrane of the nose and pharynx was atrophic, the vocal cords red, and without ulceration, their surfaces covered with crusts, which filled the glottis and caused dyspnœa. The treatment consisted of brushing with iodized glycerine and the use of laryngeal bougies.

FRÄNKEL declared the case to be atrophic laryngeal catarrh, which has nothing in common with Stoerk's blennorrhœa, because this always commences with abundant nasal secretion.

HEYMANN had seen many cases of Stoerk's blennorrhœa, but agreed with Fränkel that this was not such a case.

BAGINSKY had seen some cases of Stoerk's blennorrhœa, with concretion of the ligaments, and recommends an internal treatment with iodide of potassium.

LUBLINSKI declared this to be a case of laryngitis sicca.

VIRCHOW said that these forms must not be called atrophic, but retrograde inflammations.

KRAKAUER believed that his case was Stoerk's blennorrhœa, because the crusts were much in excess of laryngitis sicca.

Meeting, December 7, 1887.

BARTH.—*Closed Nose and Purulent Middle Ear Inflammation.*

THE author has often observed the combination of these affections. In all cases of middle ear affections the nose must be thoroughly examined. LUCAE had stated this fact nineteen years before.

Meeting, December 21, 1887.

HAHN demonstrated two patients in whom he had extirpated the larynges on account of carcinoma. One of them, extirpated a year ago, has now a tumour on the tracheal wound; this tumour is an enchondroma multiplex and cannot be operated on. The second patient, now seventy-five years old, was operated upon in 1880 and has had no recurrence.

B. FRÄNKEL read a letter from SWIDERSKY relating a case of spontaneous expulsion of a fibroma after brushing with ergotine. Swidersky believes that the medicament has in these cases the same effect as in fibromata of the uterus. Fränkel also related a case of spontaneous retrogression of a polypus.

Society of Physicians in Vienna.

Meeting, November 11, 1887.

HAJIK.—*On Ozæna.*

IN ten cases the author has found seven times the pneumonia coccus of Friedlander. Other microbes also occur, but the author does not believe that ozæna is a parasitic disease.

Michael.

British Medical Association: Birmingham and Midland Counties Branch.

October 13, 1887.

HASLAM, — (Birmingham).—*Epithelioma of the Lower Jaw and Floor of Mouth.*

EXHIBITION of patient. In this case, both lingual arteries had been tied in order to reduce the nutrition of the growth.

SIMON, — (Birmingham).—*Tracheotomy for Foreign Body.*

NARRATION of a case in which a damson stone had been impacted in the air-passages, and had subsequently been expelled through a tracheotomy wound.

British Medical Association: New South Wales Branch.

September 2, 1887.

TWYNHAM, G. E. (Sydney).—*Thyroidectomy.*

PAPER read and patient exhibited. (A report of the paper is not given.) A discussion followed.

SKIRVING, R. SCOT (Sydney).—*Tracheotomy.*

PAPER read. The discussion which followed dealt with the questions of anæsthetics, and the value of the isthmus of the thyroid gland as a mark of demarcation between the "high" and the "low" operation—some members with experience of tracheotomy stating that they had never seen the isthmus during the operation. The discussion elicited nothing new.

[As a general rule, we are inclined to believe that if an operator fail to find the thyroid isthmus, it must be mainly his own fault.]

British Medical Association: Dorset and West Hants Branch.

October 5, 1887.

MACDONALD.—*Cancer of Œsophagus.*

DEMONSTRATION of specimen.

Brighton and Sussex Medico-Chirurgical Society.

October 6, 1887.

BABER, CRESSWELL (Brighton).—*Pharyngo-Mycosis Benigna.*

EXHIBITION of patient. In a man, aged thirty-four, the tonsils and base of the tongue were affected, and had much improved by persistent painting with absolute alcohol (as recommended by Frankel), combined with mechanical removal of the deposits, which contained leptothrix.

LARKING, A. E. (Brighton).—*Anomalous Ulceration of the Throat.*

EXHIBITION of a girl, aged thirteen, who had suffered from severe ulceration of the fauces, thought at first to be strumous, owing to her presenting no signs of congenital syphilis. Her brothers were the subjects of congenital syphilis, and immediate benefit ensued on commencing anti-syphilitic treatment.

[We are unable to recognize the anomalous element in this case. Such ulceration is much more likely to be syphilitic than strumous.]

Cambridge Medical Society.

May 8, 1887.

WHERRY (Cambridge).—*Fatty Tumour of the Tongue.*

EXHIBITION of specimen.

Northumberland and Durham Medical Society.

October 13, 1887.

MURPHY, — (Newcastle). — (*a*) *Cancer of the Œsophagus.* (*b*) *Cancer of the Tongue.*

EXHIBITION of cases. In the first case, gastrostomy had been performed, and in the second, the tongue had been removed.

OLIVER, — (Newcastle).—*Thoracic Aneurism.*

DEMONSTRATION of specimen. The aneurism had caused death by direct pressure upon the trachea. Tracheotomy had been performed, and patient had lived several hours after the operation. There were none of the ordinary physical signs of aneurism during life—a point upon which the physicians who had seen the case laid some stress.

[In the absence of information on the point, we presume that, although the patient lived several hours after the performance of tracheotomy, no relief was afforded by the operation.]

Pathological Society of London.

October 8, 1887.

HANDFORD, H. (Nottingham)—*Dilatation of the Œsophagus.*

EXHIBITION of specimen from a man aged fifty-two. The œsophagus was very markedly dilated throughout its whole length, except at its passage through the diaphragm, where it was constricted to very slightly less than its normal size. There was no induration or sign of stricture. No marked microscopical changes, and no gastric disease. The aorta was also enormously dilated, and the exhibitor thought that this vessel, in its passage through the diaphragm, might have pressed the œsophagus against the central tendon, and so interfered with the free passage of food. Other possible causes were general muscular atrophy, or disease of the vagus.

Dr. BRISTOWE mentioned a similar case, in which the patient appeared perfectly well until within a few months of death. In that case there was catarrh of the œsophagus.

October 18, 1887.

LEDIARD, H. A. (Carlisle).—(1) *Sarcoma of Palate in an Otter Hound.* (2) *Large Subcutaneous Nævus from the Parotid Region.*

EXHIBITION of specimens (card).

November 1, 1887.

TREVES, FREDERICK (London).—*Congenital Cartilaginous Tumour of Neck.*

SPECIMEN shown. It was situated over the sternal end of the left sterno-mastoid

muscle, in a girl aged three years. When removed, it was seen to be a round rod, flattened at the end towards the sterno-clavicular articulation. The unusual nature of a subcutaneous, cartilaginous mass in this region, except in connection with the walls of a fistula, or with a skin tag, was commented on.

BLAND-SUTTON, J. (London).—*Fœtal Abnormalities.*
IMPERFORATE pharynx, and a communication between the œsophagus and the trachea were amongst the abnormalities described.

D'ARCY POWER (London).—*Salivary Gland, with large Salivary Calculus.*
CARD specimen.

Harveian Society of London.

October 20, 1887.

HANDFIELD-JONES, MONTAGU (London).—*Case of Myxœdema.*
EXHIBITION of a woman, aged forty-nine, the subject of myxœdema. The exhibitor (as also Dr. Alderson) stated that in several cases of this disease which had lately come under his notice, severe menorrhagia had been a prominent symptom, and he raises the question as to whether the malady may not have a predisposing cause in the state of the system induced by severe and repeated drains.

Medical Society of Manchester.

October 19, 1887.

RENSHAW, CHARLES J. (Manchester).—*Ulcer of Trachea.*
EXHIBITION of trachea and œsophagus from a case of perforating ulcer of the trachea with peri-tracheal abscess.

WRIGHT, F. (Manchester).—*Œsophagotomy.* DEMONSTRATION of case. No details given.

Leeds and West Riding Medico-Chirurgical Society.

October 14, 1887.

JACOB, E. (Leeds).—*Cancerous Stricture of the Œsophagus.*
DEMONSTRATION of specimen.

Hunter Mackenzie.

REVIEWS.

The Forms of Nasal Obstruction, by GREVILLE MACDONALD, M.D. (Lond.) *London: Alexander P. Watt, Paternoster Square.*

THE appearance of this little book may be considered an indication of the interest which is now taken in the study of nasal diseases. It consists of three lectures which were delivered at the Hospital for Diseases of the Throat, London.

The author wishes it to be distinctly understood that the work does not constitute a text-book, but is merely meant to introduce certain points in the pathology and treatment of nasal disease, as taught and practised by himself.

He thus classifies the forms of nasal obstruction :—

A. Those resulting from chronic rhinitis, with the divisions of (*a*) chronic catarrhal rhinitis with vascular tumefaction, and (*b*) chronic catarrhal rhinitis with hyperplasia; this latter having as results (1) dry hyperplastic rhinitis, and (2) dry atrophic rhinitis.

B. Obstructions arising from mucous polypi and cysts.

C. Obstructions arising from post-nasal neoplasms.

We think the author would have been justified in adding a fourth class, viz., obstructions due to malformations, or tumours, of the bony or cartilaginous septum. We do not think that any work on the subject can be considered altogether satisfactory which has this important omission.

Whilst fully impressed with the careful and, as a rule, scientific manner in which the writer has performed his task, and with the originality of many of his observations, we must take exception to certain of his views, and more especially to the somewhat too dogmatic way in which these are expressed regarding points which, to say the least, are still *sub judice*. For example, many eminent laryngologists *do* attribute some importance to the derangement of Luschka's tonsil as an occasional factor in post-nasal troubles. The author, however, considers the discussion of the conditions of this gland as "of no practical, and not much other value" (p. 8). Similarly, in writing of certain of the secondary results of nasal obstruction (and irritation ?), he refers them to anæmia, and "not to direct or reflex irritation, as some imaginative observers maintain" (p. 9). All we can say is that, judged by the author's standard, lively imaginations must be peculiarly rife amongst laryngologists.

Throughout the work are scattered many observations and notes of cases of much practical value to the physician, as, for instance, the case of a patient with laryngeal stenosis (p. 11), who could breathe easily when his nasal passages were free, but when they became obstructed, stridor ensued. "He could produce the stridor at will, by holding his nose, and adopting buccal respiration. This case suggests very strongly the importance of a healthy nose for the mechanical welfare of the larynx."

We consider that the author has not by any means proved his point that *pharyngitis sicca* is due to the inspired air "passing directly backwards along the inferior meatus, and impinging on the posterior naso-pharyngeal wall in an abnormally dry condition." It is thus considered by him as being, in a large proportion of cases, a symptom of nasal obstruction—a conclusion which many laryngologists will be inclined to dispute. The Scottish judicial verdict of *not proven* may be considered equally applicable to many of the author's other dogmatisms.

The various modes of treatment suitable to the different varieties of nasal obstruction mentioned by the author are carefully and adequately described. But here, as in classification, no mention is made of bony or cartilaginous deformities or obstructions.

A few notes, formulæ, and plates conclude a work, professedly incomplete, but in which the practitioner will find many important facts and much food for reflection, interspersed with not a few problematical conclusions.

The Throat and its Diseases, by LENNOX BROWNE, F.R.C.S. (Edin.). *Second Edition. London: Baillière, Tindall & Co.* 1887.

THIS is a work that few surgeons could have written, but which an surgeon might be proud of having placed before his profession. Though called a second edition, it is really a new book. The first edition was little more than an atlas with an explanatory text, but the book before us bears the impress of large experience and practical skill. The matter of the work is perhaps better than its method, for too often the picture of the disease is lost in the subdivision of symptoms. No doubt, in every good treatise system should be observed; but the system should be in the mind of the writer, and not constantly thrust before the eyes of the reader. No doubt, this plan makes it easier to write a book; but, as Byron has well said, "Easy writing makes d——d hard reading." The elaboration of arrangement, and the frequent use of such headlines as "voice," "respiration," "cough," "deglutition," "hearing," "sense of smell and taste," "pain," &c., are excessively trying to the cultured reader. This kind of analysis is well adapted for general books on medicine or surgery used for cramming; that is to say, it is useful for candidates for examinations. Such works, however, do not leave a permanent impression on the mind of the seeker after truth. Hence, the information contained in books like those of Aitken and Roberts is soon forgotten, whilst the knowledge imparted by Watson, Williams, or Niemeyer, lasts for a lifetime. The symmetrical arrangements of a modern text-book may, indeed, help the aspiring student; but the word-pictures of Sydenham and Boerhaave instruct the medical world for all ages. There are readers, however, we suppose, who like a subject to be broken up by the employment of elaborate subdivisions, just as there are people who enjoy double acrostics and delight in Mr. Browning's poetry, so we will say no more on this topic.

Having now relieved our feelings, we have much pleasure in calling attention to the excellent material which Mr. Browne has collected, and in acknowledging that his work shows internal evidence of having been written by a man who, though a specialist, must have had good general training before he devoted himself to expert work. The author delights to enter into details, and is not opposed to new things. Thus, we find him recommending Leiter's temperature regulators, which he seems to have found useful for applying cold to the neck in cases of tonsillitis, and he claims for this method that "it makes the practitioner able to dispense with ice, which is often difficult to obtain." Ordinary pump water reduces the temperature sufficiently for all practical purposes. In speaking of acute pharyngitis, Mr. Browne very properly protests against the use of glycerine of tannin, which is so commonly employed by the medical profession at the present time. In fact, this remedy holds the place that nitrate of silver did twenty-five years ago. The astringent remedy is not quite so bad as the caustic; but they are both injurious, and represent that routine practice which is the bane of

scientific progress in medicine. The author attaches great importance to what he calls Lingual varix, or a varicose condition of the veins at the base of the tongue, and thinks that the condition often gives rise to reflex symptoms, the real nature of which is not recognized. Mr. Browne has written an excellent article on cancer of the tonsil, and has illustrated it by a number of good drawings. He also makes some judicious remarks on lympho-sarcoma of that gland. Notwithstanding that most specialists, and the leading physicians who have had experience in the treatment of croup and diphtheria, now generally regard these two complaints as identical in their nature, Mr. Browne still adheres to the doctrine that these diseases are widely different. As regards the etiology of the disease, he maintains "that isolated cases may reasonably be explained by the actions of volatile ptomaines, accompanied or not by pathogenic germs," but by using the last phrase the author practically gives up the doctrine of ptomaines. In the treatment of this disease Mr. Browne attaches most importance to lactic acid as a local application, whilst to meet the constitutional depression he recommends "oxygen in its nascent or free state, as ozone or peroxide of hydrogen." In speaking of acute laryngitis, he observes (p. 259): "Differing from generally accepted statements, I have not found that exposure to keen winds, the inspiration of dry cold air, or of hot air, or of changes from heat to cold, *unaccompanied by moisture*, act specially as etiological factors of catarrhal laryngitis." Although moisture no doubt increases the bad effects of cold, we cannot admit that "dry cold air" does not produce catarrh; "hot air," however, has never, as far as we are aware, been accused of causing inflammation of the air-passages.

The author has modified Dr. Whistler's cutting dilator, by making the stem and olive-shaped extremity hollow, with the view of enabling the patient to breathe through the instrument during its use, or, in other words, with the purpose of enabling the surgeon to carry out the cutting process more leisurely than would otherwise be possible. On this point we may remark that the great merit of Dr. Whistler's instrument is, that by filling up the space in the larynx it puts the morbid membrane on the stretch, and in this way enables the operator to divide it. In operating with ordinary knives, it was previously found almost impossible to cut through the membrane, which yielded to the knife, instead of permitting its transfixion. It will be seen, therefore, that the feature introduced by Dr. Whistler was one of great importance, and we have found the instrument so satisfactory that we see no necessity for modifying it. Mr. Browne's observations on perichondritis are exceedingly good, the excellent photo-engravings giving the article a highly realistic character. The chapter on lupus of the mouth, pharynx, and larynx is, we believe, entirely new, and is one of the best in the book. In fact, we do not know where such a complete account of the disease can be found. The article on tuberculous laryngitis is well up to time, and the author speaks favourably from his own experience (which, however, is limited in this respect) of Krause's treatment with lactic acid. He thinks, however, that menthol dissolved in olive oil, as recommended by Rosenberg, is

likely to be of greater value. It may here be remarked that Krause has no longer the same confidence in his treatment that he had two years ago. In speaking of the extension of malignant disease through the larynx, Mr. Browne corrects an error of Dr. Semon's, who, it appears, is under the impression that the laryngeal lymphatics are much isolated, whilst those of the pharynx communicate freely with the surrounding parts. Admirable illustrations from Sappey prove that Dr. Semon is entirely mistaken. Mr. Browne's experience differs *in toto* from that of Mr. Butlin as regards the infection of neighbouring glands, and not without reason, he expresses his surprise that Butlin should have endeavoured to explain away cases described by such accurate observers as Fauvel and Victor Bruns. In speaking of the treatment of malignant disease, Mr. Browne dwells on the great dangers of complete extirpation of the larynx, and in support of this view he quotes a short but excellent *résumé* of the subject by Solis Cohen. He reports a case of his own of partial laryngectomy, in which the patient was alive nearly four months after the operation, and had not lost weight during the latter three months.

Referring to neuroses of the larynx, Mr. Browne calls attention to Dr. Semon's theory "that there is a proclivity of the abductor fibres of the recurrent laryngeal nerve to become affected sooner than the adductor fibres, or even exclusively in cases of undoubted central or peripheral injury or disease of the roots or trunks of the pneumogastric spinal accessory or recurrent nerves." "This view," Mr. Browne observes, "has been advanced with great enthusiasm and reiteration by Semon," who, indeed, speaks of it as if it were a "law" little less important than the Newtonian doctrine of gravitation. In both physiology and pathology it is always dangerous to assert a negative, and it remains to be seen whether this so-called "law" will not be found to have many exceptions. Even, however, if it be a law, it does not appear to have any great importance either in the elucidation or the cure of any morbid condition. Mr. Browne does not even give Dr. Semon the credit for this wonderful law, but says the view originated with Rosenbach, of Breslau, and that the same idea had been in a measure foreshadowed long previously by Gerhardt, Mackenzie, and others. The author points out that some of the most able physiologists and laryngologists, such as Frank Donaldson, junr., of Baltimore, Hooper of Boston, and Krause of Berlin, do not accept Semon's theory.

Perhaps the least satisfactory chapter in Mr. Browne's book is that on spasmodic affections of the larynx, the important subject of spasm of the glottis being dismissed in two pages. Nervous laryngeal cough only occupies one page; and in treating of this affection, in our opinion, undue importance is attached to uterine irritation. The rare phenomena known as reflex epileptiform neuroses of the larynx are, on the other hand, discussed with excessive detail, eight pages being devoted to this subject. The author remarks that, up to the present time, this subject has not been treated in any systematic work on diseases of the throat, and though, perhaps, a passing allusion should have been made to this matter, we see no reason for discussing it at any length. The fact that patients suffering from very violent cough have been occasionally known to fall down insen-

sible, or even to have slight convulsions, is a matter of familiar observation. Every general practitioner of any experience must have met with many instances of this sort. The chapters on nasal and ear disease are short and suggestive, but do not pretend to be in any way exhaustive. We have already remarked on the want of sense of proportion in the treatment of some of the subjects to which this book has reference ; and as this is a fault which could easily be remedied in a future edition, we must again allude to it. Thus lupus, a disease which may be considered incurable, occupies fourteen pages, whilst the very important practical subject of benign growths is allowed only three pages more ; thirty-one pages, on the other hand, are devoted to malignant neoplasms.

The work contains no less than one hundred and twenty illustrations in colour and two hundred engravings. Although these coloured illustrations may attract the unlearned, we cannot help regarding them as not entirely satisfactory. The drawing is, of course, good, having been executed by so excellent an artist as Mr. Browne, but the colouring is very unlike nature. It is a question, however, whether any illustration can give a correct representation of the appearances seen in the laryngeal mirror. The most artistic coloured drawings which have ever appeared are, no doubt, those of Türck, but they are much too yellow. Mr. Browne's, on the other hand, are either too red or have a blue or greyish tint which is not met with in nature. In order to bring the price of the book down to a moderate sum, only three or four stones have been used in the lithographing process, whereas to get anything approaching to a faithful representation, twenty to twenty-five stones would have been required. Less showy, but far more meritorious, are the photo-engravings by Henschell's process. Many of these are really equal to fine etchings, and they have a life-like exactitude, which commends them not less to the experienced laryngoscopist than to the young student. A good index completes the work, which will be found a useful and trustworthy guide in the treatment of a numerous and highly important class of diseases. The book is well got up in every respect, and does credit to the publisher as well as to the author.

Manual of Tracheotomy, by T. RENAULT. *Paris*, 1887.

A VERY practical little book, which will be of great service to practitioners by presenting, condensed in a few pages, the minute rules for this important operation. Commenced by Renault, this manual was finished by Darion and Carron de la Carrière, all old students of the Hôpital des Enfants.

London : Taraon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Article, p. 99.—On Aerial Goitre and Tracheocele, by R. Norris Wolfenden.

New Instruments and Therapeutics, p. 109.—Maw, Son & Thompson: Balin's Improved Fur-Respirator. W. W. M.: Climate for Asthma. Clay: Treatment of Cancer. Greene: Condy's Fluid in Syphilitic Glossitis. Ruault: Naphtholized Water in Ozæna and Purulent Rhinitis. Charteris: Climatic Treatment of Phthisis in Colorado. Hambleton: Treatment of Consumption. Hopman: Large Doses of Creosote in Laryngeal and Pulmonary Phthisis.

Diphtheria, p. 110.—Delthill: Relation of Animal to Human Diphtheria. Cooper and Wilks: Diphtheria and Main Drains. Barrett: Diphtheria Circumscripta. May: Treatment of Diphtheria. Roulin: Treatment of Diphtheria by Phenol Douches. Gauchier: Treatment of Diphtheritic Angina. Ruhemann: Ataxia following Diphtheria.

Nose and Naso-pharynx, p. 112.—Jarvis: Two Cases of Congenital Occlusion of the Anterior Nares. Delavan: Etiology of Deflections of the Nasal Septum. Jalaquier and Ruault: Polypus of the Right Nasal Fossa. Chatellier: Hypertrophy of the Nasal Mucous Membrane. Woolen: Hypertrophy and Polypus of the Naris. Cheatham: Nasal Reflexes as Cause of Diseases of the Eye. Cheatham: Hypertrophy of the Third Tonsil. Killian: Empyema of the Antrum of Highmore.

Mouth, Tonsils, Pharynx, &c., p. 115.—David: Aphthous Stomatitis and its Origin. Schliferowitsch: Tuberculosis of the Mouth. Gleitsmann: Hypertrophy of the Tonsil of the Tongue. Robertson: Hypertrophy of Lingual Tonsil. Savill: Epithelioma of the Œsophagus, with Gangrene of the Lung. Eglinton: Swallowing Artificial Teeth. J. B. E.: Passage of Foreign Bodies through the Alimentary Canal. Groom: Passage of Foreign Bodies through the Alimentary Tract. Cadet de Gassicourt: Pultaceous Angina an Initial Symptom of Typhoid Fever. Koch: Paræsthesia of the Upper Air Passages. Iversen: Resections of the Pharynx and Œsophagus.

Larynx, p. 120.—Symonds: Intubation of the Larynx. Parker: Partial Excision of the Larynx, Pharynx, &c., for Epithelioma. Editor of British Medical Journal: Excision of Larynx for Malignant Disease. Stoerk: Extirpation of the Larynx for Carcinoma. Solis-Cohen: Appearance of a Larynx nearly Twenty Years after Extirpation of an Epithelioma. Meiser: Removal of Endo-Laryngeal Tumours. Editors of Lancet: Cancer. Wagner: Six Cases of Cancer of the Larynx. Newman: Seven Cases of Cancer of the Larynx. Defontaine: Inter-crico-thyroid Laryngotomy. Zurllinger: Etiology of Chorditis Vocalis Inferior Hypertrophica. Cadet de Gassicourt: Dangers of Chloroform in Tracheotomy. Renton: Case of Tracheotomy. Simon: Foreign Body in Right Bronchus; Tracheotomy. Bernard: Tracheotomy for Croup. Zuckerkandl: Asymmetry of the Larynx. Solis-Cohen: Hernia of the Laryngeal Sac. Roe: Paralysis of the Abductors of the Vocal Cords. Gleitsmann: Traumatic Hæmatoma of the Larynx. M. B.: Laryngeal Spasm.

Neck, &c., p. 125.—Editors of Lancet: Exophthalmic Goitre. Vetlesen: Etiology of Goitre. Tsaryrogboas: Goitre in Asia Minor. Harris and F.R.C.S.: Strumous Ulcers. Walters: Discoloration of the Skin by Nitrate of Silver. Dixon: Salivary Calculus. Bresgen: Nervous Cough. Budd: Is Cancer Contagious? Strange: Gangrenous Abscess of the Lung.

Association and Congress Meetings, p. 128.—Ninth International Medical Congress.

Reports of Societies, p. 138.—Sheffield Medico-Chirurgical Society; South-east Hants Medical Society; Harveian Society of London; Brighton and Sussex Medico-Chirurgical Society; Leeds and West-Riding Medico-Chirurgical Society; West London Medico-Chirurgical Society; Medical Society of London; British Medical Association—Birmingham and Midland Counties Branch; Northumberland and Durham Medical Society; British Medical Association—Yorkshire Branch; Sunderland and North Durham Medical Society; Medical Society of the Hospitals; British Medical Association—South-Eastern Branch, East Kent District; Clinical Society of London; Wiener Doctoren Collegium; Berlin Medical Society.

Reviews, p. 142.—Woakes, Edward: Nasal Polypus, with Neuralgia, Hay Fever, and Asthma, in relation to Ethmoiditis. Scanes, Spicer: Forms for systematically recording Observations and Results of Treatment in Affections of the Throat and Nose. Michael, J.: The Formation of the Singing-registers.

New Preparations, p. 145.—Pumilio Pine Products. Pastilles of Iodol. Æsculap. Natural Carlsbad Sprudelsalt. Vichy Water.



PINUS PUMILIO.

"THE PINE TREATMENT."

Successful in Gout, Rheumatism, and Diseases of the Throat and Lungs.

PINOL is entirely different from the common oils of pine, and is useful for internal administration, for which purpose the inferior oils are unfit.

PINOL is distilled ONLY from SNOW-GROWN PUMILIO PINE.

The fragrance of PINOL is so delightful and refreshing that many (especially invalids) prefer it to any other odour for purifying and disinfecting the air of the sick room, and imparting the agreeable and healthful properties of the Alpine atmosphere.

Our Pine Products may be ordered of any Chemist, and we shall be happy to supply Free Samples to any Physician desiring to try them.

PRICES:

Supplied by all Chemists to the Medical Profession as follows :—

Pinol, small size, 1s. 3d. ; Retail, 1s. 6d.
Large size, 2s. ; Retail, 2s. 6d.

Extract Pumilio Pine, for Baths, etc., 9d. ; Retail, 1s.

Pinol Pastilles, 1s. 3d. ; Retail, 1s. 6d.

PINOL.

(BURROUGHS, WELLCOME, & Co.)

From *Journal of Laryngology*, Dec., 1887.

We have received this preparation, and are of opinion that it is one of the purest in the market. It is distilled from the needles of the Pinus Pumilio, and is, without doubt, one of the most useful of the essential oil inhalations for the treatment of chronic and sub-acute laryngeal and pharyngeal conditions.

THESE ARE EXACT COPIES OF OUR LABELS.

The drug is used in coryza, hay fever, quinsy, clergyman's sore throat, aphonia, asthma, chronic bronchitis, bronchorrhœa, consumption, genito-urinary and skin affections, gout, rheumatism, lumbago, sciatica and general debility; also for sprains, strains, bruises, etc.

Burroughs, Wellcome & Co.

PINOL (Burroughs).

Pinol is the pure essence or volatile oil distilled from the needles of the Pinus Pumilio, growing in the perpetual snow of the Alps. It is distinguished from the common pine oils by superior medicinal and sanitary properties, and by its exquisite fragrance. Dose, 2 to 5 minims in water.

(We prepare Pinol Tabloids for use in the Burroughs' Inhaler.)

Snow Hill Buildings, London, E.C.

DIRECTIONS.—Pinol may be used in inhalations (from Burroughs' Ammonium Inhaler, or a spray or steam atomizer), as a gargle, for fumigations, and as an embrocation or lotion, and taken internally. It is much employed as an embrocation in rheumatism after Pine-Extract baths.

DIRECTIONS.

To PREPARE A BATH.—Empty this bottle of Extract into an ordinary bath filled with water of any desired temperature. Half a bottle is sufficient for a child's bath. Care should be taken to keep warm after a hot bath.

To PREPARE OINTMENTS.—Ointments are best prepared for skin diseases, burns, etc., by incorporating with Lanoline. In many cases it is, however, advantageously employed pure.

Burroughs, Wellcome & Co.

EXT: PUMILIO PINE

(BURROUGHS).

[*Extractum Pinus Pumilionis.*]

This Extract of the Pumilio Pine has a rare fresh fragrance, is readily soluble, and never stains. It is used for preparing baths, liniments, ointments and plasters, in cases of chronic rheumatism—articular and muscular—lumbago, gout, neuralgia, sciatica, skin affections, insomnia, neurasthenia and fatiguing exercise. A hot pine bath is desirable to prepare the skin for ready absorption of PINOL in rheumatism, etc.

Snow Hill Buildings, London, E.C.

DIRECTIONS.

LINIMENTS.—The Extract may be employed as a liniment in muscular pains, sprains, contusions, etc.

PLASTER.—Place the bottle in hot water, and when the Extract is thoroughly warmed, rub it evenly on a piece of warm chamois or flannel of required size.

The best time for a hot pine bath is before going to bed.

CONTENTS.

Original Articles—

1.—On Deviations and Spurs of the Nasal Septum. By Drs. Moure and Bergonié (Bordeaux), p. 495.

2.—On the Nature of the Tonsils and Lymphoid Tissue of the Pharynx. By Mr. Mayo Collier, p. 502.

Abstracts—

Therapeutics and Diphtheria, p. 504.

Mouth, Tongue, Pharynx, &c., p. 508.

Nose and Naso-Pharynx, p. 514.

Larynx, p. 522.

Neck, &c., p. 526.

Report of the International Congress of Berlin, p. 528.

Report of the American Laryngological Association, p. 535.

The British Laryngological and Rhinological Association, p. 545.

New Instruments, p. 546.

A DELICIOUS FOOD.

LONDON.] DECEMBER. [1890.

KEPLER MALT EXTRACT.

THIS preparation is rich in nutritive properties, and contains a large amount of diastase or vegetable ptyalin, which converts farinaceous foods into the assimilable forms of maltose, dextrins, and natural phosphates, the force-producing and vitalising properties of barley.

Maltose.—This is formed when farinaceous foods are acted upon by ptyalin or the pancreatic ferment; it is very diffusible, is perfectly absorbed by the lacteals, and is of the first importance as a nutrient in wasting disease.

Dextrin.—An intermediate stage between starch and maltose, an easily assimilated form of proteids, possessing eminently useful nutritive properties.

Natural Vitalising Phosphates.—These are utilised by the economy as nerve and brain tonics.

The Kepler Malt Extract may be used with advantage to sweeten porridge, rice, hominy, &c. Upon the addition of the Extract to peptonised milk and starchy foods, the diastase contained in the Extract of Malt digests the starch, and renders it easy of assimilation. Children like it when spread upon bread and butter. It forms a very pleasant food, and is eminently adapted for employment in cases of failing nutrition. Puddings made with the Kepler Malt Extract are easily borne by the most delicate stomach. Its chief triumph has been as a menstruum for administering Cod Liver Oil in the form of solution. This preparation is widely known as the Kepler Solution of Cod Liver Oil in Malt Extract.

The *Lancet* says of Kepler Extract of Malt: "The best known, and in this country the largest used Extract of Malt."

The *Medical Record* (London) says: "The Kepler Extract of Malt is the best, the richest in diastase."

The Kepler Extract of Malt and the Kepler Extract of Malt with Cod Liver Oil (Kepler Solution) supplied to the Medical Profession in bottles containing ¾lb. and 1½ lb. at 1s. 10d. and 3s. 2d. Retail prices, 2s. 6d. and 4s. Special terms to Hospitals. Supplied by all Chemists throughout the World.

Burroughs, Wellcome & Co., Snow Hill Buildings, London, E.C.,

Will be happy to supply trial Specimens to medical men free on request.

THE
JOURNAL OF LARYNGOLOGY
AND RHINOLOGY.

VOL. II. MARCH, 1888. No. 3.

ON "AERIAL GOITRE" AND "TRACHEOCELE."

Galenus[1] and Paul d'Egine[2] seem to have been acquainted with aerial tumours of the upper air-passages, the latter referring to bronchocele or tracheocele.

Larrey[3] described, under the name of *Aerial Goitre*, a form of aerial tumour which is now generally thought to have been emphysema of the neck. It consisted of one or many aerial tumours situated in the front of the neck, and principally at the side of the larynx. These tumours, "which may acquire a considerable size, arise from more or less violent efforts, necessitated by cries and shouting. The air which has served for inspiration being then expelled outward by expiratory effort, with all the modifications required to give the voice or cries the desired intonation, insensibly produces these tumours. The air is, however, arrested in the tortuous cavities at the summit of the trachea, larynx, or parts behind the mouth, gradually distending the muco-cellular tissue of the air-channels, and determining the formation externally of small herniæ of these membranes, either between the great cornua of the hyoid bone and the thyroid cartilage, or across the interstices of the cricoid and first ring of the trachea. The vesicles thus produced grow rapidly and rise externally to the edge of the jaw, but present this feature, that gradual and uniform pressure causes them to disappear wholly or in part. This phenomenon, together with the absence of pulsations or arterial thrill, serves to distinguish this kind of pneumo-bronchocele from aneurysmal goitre." It was seen in Egypt amongst the blind, who are employed to chant verses of the Koran from the minarets at all hours of the day and night, for the purpose of marking the time and calling the attention of the faithful to their duties. The pouches produced are described by Larrey as like those found in certain apes. They appear only at the time these "réligieuses" commence to chant their exercises, and the sufferers are compelled to compress them. But when the internal openings are much dilated, so that aerial tumours of the size of a fist are instantly produced by the expiratory effort, these persons are permitted to retreat into the privacy of the "piscines" of the temples. Larrey had seen this condition in two officers who used the voice much for instructing troops. One had a

[1] *De Compos. Medic. per Genera.* Lib. VI., cap. xiv.
[2] Lib. VI., cap. xiv.
[3] "Du Goitre aérien ou Ventriculaire." *Clin. Chir.* t. II., 1814.

tumour on each side of the larynx of the size of an apple, crepitant to pressure, thin, and knobby and indolent. Both subjects were aphonic, and could be heard only when compressing the goître with both hands, and this pressure caused the goître to disappear. The latter two cases certainly bear a very strong resemblance to tracheocele, and as Jacquoud[1] remarks, might well be produced by a rupture of the tracheal membrane and outward escape of air, which, however, is of course different to simple hernia.

"Congenital bronchocele" was described by Gohl,[2] the record being, however, very incomplete. The case was diagnosed from the fact that the tumour had increased on inspiration and crying, and was unaffected by expiration. There was, moreover, in this case a complication with struma. A case quoted by Riegel,[3] under the head of "Congenital Fistula of the Neck," is accepted by Eldridge[4] as tracheocele, but there do not seem any grounds for reversing the original diagnosis of Riegel. Lizé[5] described, in 1861, a case (under the title of emphysematous goître) of a girl seventeen years old, in whom a gaseous tumour developed suddenly from violent shrieking during labour. It occupied the right side of the neck, and disappeared in two days. Leriche's[6] case of "aerial goître," occurring in a child eight months old, from coughing; and Behr's [7] case of gaseous thyroid tumour in a girl of fourteen, as the result of coughing, are all, undoubtedly, cases of emphysema (very similar to Larrey's cases), and are wrongly included under the term tracheocele.

Emphysematous tumours of the thyroid gland have frequently been recognized, and have been variously designated "struma aera ventosa et pneumatophyma," "bronchocèle," "aérocèle," and by Larrey, as before mentioned, "goitre aérien," or "pneumo-guttural." Such cases have been recorded by P. Franck, Richter, Schmalz, and Heidenreich, and they result, as Houel[8] properly remarks, not from any primary alteration of the thyroid gland, but from a lesion of the air-tract, such as rupture, which permits the passage of air outwards: such rupture has been known to occur during parturition, at the end of violent efforts during vomiting, after bursts of laughter, singing, and playing wind instruments. (Franck, &c.)

While aerial goître used to be much written about, it is no doubt true, as H. Rendu remarks, that there has been no veritable observation of a gaseous tumour, developed in the interior of the thyroid gland, without a communication existing either with the exterior or with the respiratory tract. Heidenreich, indeed, said he saw a gaseous tumour surrounded by a thick wall situated in the substance of the thyroid gland, but it cannot be imagined that a gaseous tumour could develop in the substance of such a gland without some external communication. It is far more probable,

1 *Dic. de Méd. et de Chir.*, p. 36. Tracheocele.
2 *Ammon. Die angebornenen chir. Krankheiten des Menschen.* Berlin, 1842.
3 *Ziemssen's Encyclopædia*, vol. IV.
4 "On so-called Hernia of the Trachea." *Am. Journ. Med. Sci.*, July, 1879.
5 *Soc. de Chir.*, 1861.
6 *Soc. des Sci. Méd. de Lyon*, 1868.
7 *Wochens. f. d. ges. Heilkunde, Berlin*, 1836.
8 "Tumeurs des Corps Thyroïdes." *Thèse de Conc. Agrég.* Paris, 1860.

as Rendu remarks, that such a communication had previously existed, and the emphysematous enlargement had subsequently become encysted. One explanation of these aerial goîtres may be found in the observation of Duplay, who found two bursæ nearly constantly interposed between the lobes of the thyroid gland and the trachea. If a rupture of the trachea should admit air into these sacs, they naturally would expand. Heidenreich believed in dilatations of the tracheal rings themselves. All these cases in which the trachea would undergo a rupture by a sudden effort leading to extravasation of air into surrounding tissues would lead to sudden development of a crepitant, emphysematous tumour, which would be diffused, speedily absorbed (as in the cases of Lizé, Leriche, &c.), or, in very rare cases, such as Heidenreich's, might become encysted and localized. But most of the older observations are untrustworthy. Some of the older writers admitted hernia of the trachea, but no case was described with accuracy until Gayet[1] recorded an undoubted example of hernia of the trachea in 1867.

Virchow[2] has described what he has called "cystic trachectasies," which have their seat in that part of the aerial channel which is a little above and behind the sternal fourchette. They are dilatations of the posterior wall of the trachea, commencing in a series of flat depressions or excavations of the inner wall, which, little by little, coalescing, form a collective tumour, which steadily increases. Being unable to develop backwards by reason of the œsophagus and vertebral column, they extend laterally, and, under certain conditions, appear as veritable tumours above the clavicle, below and behind the thyroid gland, and at the sides of the trachea, and may then simulate a deep-seated goître or cyst. While originating at first as a hernia ("bronchocele"), they may later on become pedunculated. The orifice of communication may then become closed, and there results a pouch by the side of the trachea, filled with thick and clear mucus. Virchow[3] also describes, besides the dilatations of the trachea just mentioned, which might easily be confounded with cystic goître, and which, in place of air, habitually enclose only mucus, a dilatation of the ventricles of Morgagni, which may be called "ventricular laryngocele." In these cases there are seen small lengthened sacs, with thin walls, proceeding from the upper part of the ventricles by a narrow orifice, and sometimes extending to the upper border of the thyroid cartilage, and even to the hyoid bone, where they terminate in a club-shaped extremity, generally unilateral, but he once met with them on both sides. Their walls are smooth, the inside is lined with ciliated epithelium, and they contain air. It is impossible to confound them with goître, as they are placed within the thyroid cartilage. Once he met with a small cyst near the epiglottis and hyoid bone, which resulted from strangulation of the neighbouring sac.

We may dismiss the "aerial goître," so much written of by the older authors, as an impossible condition; the only case worth consideration, viz., that of Heidenreich, being explicable on other grounds, as already

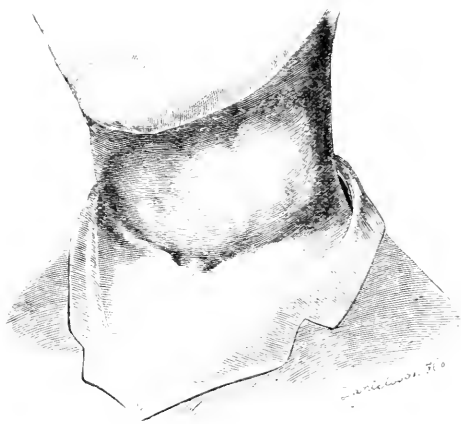
[1] *Mémoires de la Soc. des Sci. Méd. de Lyon.* 1865-6, tome V.
[2] *Pathologie des Tumeurs.* Translation by Aronssohn. Tome I., p. 261. 1867.
[3] *Op. cit.*, tome III.

shown. Virchow's "trachectasies" and "ventricular laryngocele" appear to be curiosities. In connection with the former it may be mentioned that Rokitansky[1] has described sacciform diverticula of the trachea, originating in hypertrophy and dilatation of the muciparous glands, and either of these conditions might reasonably play some part in the development of "tracheoceles." I scarcely think that anyone would confuse these aerial tracheal tumours with pulmonary hernia (or pneumatocele), which was ably described by Dr. John Cockle[2] in 1873.

"Tracheocele," or "tracheal hernia," escapes the attention of most writers of text-books, but is important enough to deserve recognition at their hands. Eldridge,[3] who wrote a careful essay on the subject in 1879, Cohen[4] and Morell Mackenzie[5] are the only English writers who have dealt with the subject in detail. Careful essays have also been contributed by Jacquoud[6] and Rendu.[7] I scarcely need to apologize for again directing attention to a condition which has received so little notice, more especially as I believe many cases must occur in practice, some of which escape detection, others of which are unrecorded. This is unfortunate, for the subject is interesting from many points of view. Three cases have occurred in my practice during the last eighteen months, and I herewith relate them :—

I.—The patient, a well-developed and intelligent German, aged twenty, an hotel waiter, noticed first in December, 1886, a fulness of the front of the neck above the sternal notch, forming a tumour on each side of the trachea, which was treated by a local practitioner for a goître, which it fully resembled. Under treatment with iodine, it seemed to diminish for a time, but not completely, and subsequently increased again. At the first inspection at the Throat Hospital, where he came for treatment, I found a soft enlargement of both lobes of the thyroid gland, and noticed that on coughing the tumour became a little more prominent. He complained of a certain degree of dyspnœa on exertion, and an uncomfortable feeling of oppression in breathing. The voice was hoarse, the vocal cords congested, and their movements sluggish. At first I took the case to be one of simple goître, and treated this by the insertion of electrolytic needles and Faradism. The goître was soon dispersed under daily applications, and it then became evident that there was an aerial tumour communicating with the trachea, to which my attention was first directed by the patient saying to me, "I can blow it up." While the patient was at rest there appeared to be scarcely any more than fulness, chiefly located over the right side of the neck in the region of the lower part of the thyroid. When the tumour was fully distended by expiratory effort with the mouth and nares closed it appeared to be rounded and well defined, rising above the cricoid cartilage extending on the right side under the edge of the sterno-mastoid muscle, and obliterating the sternal notch in its upper part. On the left was a similar but smaller tumour, not extending quite to the cricoid cartilage, or to the edge of the sterno-mastoid. The two tumours appeared to be connected by a swelling in front of the trachea, which inflated at the same time as the other portions. I and others thought these two tumours to be distinct, since

[1] *Path. Anatomy*, vol. III., p. 4.
[2] *Med. Times and Gaz.*, Jan. 4 and 11, 1873.
[3] *Am. Journal of the Med. Sciences.* New Series, vol. LXXVIII. July, 1879.
[4] *Ashurst's Encyclopædia*, vol. V. [5] *Dis. of Throat and Nose*, vol. I., p. 537.
[6] *Dic. de Méd. et de Chir.*, I., 36.
[7] *Dict. Encyclopédique des Sci. Méd.* 4me sec., tome IX.



TRACHEOCELE

(*The Tumour distended voluntarily.*)

prevention of distension of the main tumour on the right side by pressure did not prevent the inflation of the tumour on the left side during forced expiration. The circumference of the neck when at rest was 13¾ inches, when inflated 15 inches. Coughing caused some distension of the tumours: external pressure would prevent the distension, but while pressure applied to a spot just below the cricoid cartilage on the right side would prevent inflation of this side, the tumour on the left side would be fully expanded, and *vice versâ*. The tracheal sounds were heard on auscultation intense in character; the tumour was not tympanitic, probably owing to its possessing a thick wall, and no crepitation could be elicited. As in other cases described, the larynx was somewhat congested, and the muscular movements sluggish; voice was husky and weak. The only treatment adopted was the application of a pad to obtain compression, which the patient was directed to wear continuously. No history of violent expiratory effort, coughing, or vomiting could be obtained. I append a drawing of this case, which was interesting, because a goître complicated the tracheocele, the former masking the condition for a time.

II.—E. B., aged thirty, an unmarried woman occupied in needlework, attended my clinic at the Throat Hospital, complaining of a "swelling on the left side of the neck." She stated that she had frequently suffered from enlarged glands in previous years, and had noticed this tumour fifteen months previously for the first time. A doctor whom she consulted informed her that she had "Derbyshire neck," and painted it with iodine. "When the patient is quiet and not speaking, "a rounded swelling is seen beneath the tendon of the left sterno-mastoid muscle, "commencing half an inch above the clavicle, and extending for one inch upward. "On forcible expiration with the mouth and nose closed, the swelling increases in "size, extending up to the middle line of the neck, and outwards to the supra-"clavicular fossa. The expansion of the tumour can be prevented by pressing on "a spot on the left side of the trachea. Coughing causes distension of the tumour. "Blowing breath sounds are heard on auscultation, and the tumour is tympanitic "to percussion. There is a slight amount of dyspnœa on exertion, and the voice "is weak but not hoarse. There is nothing abnormal in the larynx. The patient "is a pale, weakly-looking woman, who has suffered much from vomiting, with "violent retching, and thinks that this may have caused the tumour to appear in "the first instance."[1]

III.—The third case occurred in a weak, debilitated man of forty-five. On removing the beard two months before coming to me, he had noticed for the first time a tumour on the right side of the neck by the side of the trachea, and a little below the cricoid cartilage, of the size of a Tangerine orange, hard but compressible (the sac wall was probably very thick). It could be almost completely emptied by external pressure. It enlarged considerably on expiration, cough, and distending it at will: it was not tympanitic to percussion, but blowing breath sounds were heard over it. The vocal cords were congested, and their movements sluggish.

But few cases of tracheal hernia have been put on record. Eldridge, in 1879, could only find recorded nine cases, of which three, however, were evidently not tracheocele. Cases must frequently have occurred, the true nature of which has been overlooked, and the practitioner may be excused for calling such cases goître. He is not likely to recognize the true state of affairs unless he has caused the patient to voluntarily distend

[1] For the notes of these two cases I am indebted to my able clinical assistants, Dr. Stephen Breckenridge, of U.S.A., and Dr. Hugh Montgomeri, of Penzance.

the tumour. In all cases of supposed goitres he should, therefore, bear in mind the possibility of tracheal hernia.

Such cases as I am able to find recorded I will now refer to before discussing the general subject of tracheocele.

GAYET[1] described a case in 1867 which possessed the following points of interest. A joiner presented a tumour at the lower part of the median portion of the neck, which had existed for nine months, and had gradually increased in size. It passed under the inner edges of the sterno-mastoid muscles, becoming prominent, hard and elongated from below upwards when the muscles were thrown into action; becoming soft and diminished in size when the muscles were relaxed. It was also swollen and distended during forced expiration, disappearing during inspiration. It was soft to the touch and reducible by manipulation, but evidently presented a sac with thick walls. The tumour was independent of the thyroid gland, and communicated with the trachea probably below the cricoid cartilage.

DEVALZ,[2] in 1873, recorded a case in which the tracheal hernia had occurred ten years previously, consequent upon an attack of bronchitis attended with violent cough. It varied with respiratory movements, and formed a pyriform swelling on each side of the trachea, like hypertrophy of the lateral lobes of the thyroid on coughing. The appearance of the swelling could be prevented by pressure upon the trachea. The tumour was soft and readily compressible.

FAUCON,[3] in 1874, saw in a man of fifty-four a swelling of the size of a hen's egg to the right of the trachea, resembling a bronchocele, but differing from the latter in being soft, elastic, and increased in size by coughing, hawking, and blowing the nose. The tumour had first appeared after vomiting, but he had suffered for many years from bronchial catarrh. The tumour was tympanitic and voice weak. A second case of Faucon's[4] was that of a child of eighteen months old, and the tracheocele arose through exertion, receded spontaneously, and could be reduced.

ELDRIDGE'S[5] case occurred in a man of twenty-six, and the tumour had first appeared about seven months previously, being little more than a swelling on each side of the trachea, associated with occasional noisy and difficult breathing. It had gradually increased along with the severity of the symptoms, which, previously paroxysmal, now became constant, and there was suffocative dyspnœa. The size of the tumours could be increased by coughing and on forced expiration. The swellings were independent of each other, and looked like thyroid hypertrophies. With severe dyspnœa the tumours were much dilated, and when tensely distended the introduction of a hypodermic needle gave exit to a stream of air sufficient to extinguish a lighted match. Tracheotomy was proposed and refused.

DÉTIS,[6] in 1883, described the case of a merchant, aged twenty-nine, of previous good health, who, after severe coughing in the course of an acute

[1] *Mémoire de la Soc. des Sci. Med. de Lyon.* Loc. cit.
[2] *Gaz. des Hôp.*, 1873, 129.
[3] *Archives Méd. Belges*, Jan., 1874.
[4] *Ibid.*
[5] *American Jour. of the Med. Sci.*, July, 1879.
[6] *Cent. für Chir.*, July 7, 1883.

bronchitis, noticed a tumour the size of a hazel nut just above the sternum, which in three days had increased to the size of a pigeon's egg. Remaining stationary for three weeks, it suddenly opened, discharged pus and blood, and became reduced in size. It then grew again slowly for a time, remaining, however, softer and smaller than before. It increased in size during expiration, and diminished during inspiration. Compression caused it to disappear, and fine crepitus was elicited. Permanent compression with a truss cured it in six weeks. (This was probably a case of tracheocele, resulting from closure of a fistula.)

INGALS,[1] in 1885, related the case of a labouring man, aged fifty-four, suffering from chronic bronchitis with emphysema, in whom an irregularly hemispherical tumour, of the size of half a hen's egg, was detected. The tumour lay in front of the trachea, in the position of the thyroid isthmus, was firm but elastic to the touch, moved upwards and downwards with deglutition, but less so than a bronchocele. It was not materially altered in size by pressure, but enlarged to the size of a small orange on sudden expiratory effort, the left side of the neck and supra-clavicular region bulging out half to three-quarters of an inch on expiratory effort or coughing.

R. W. PARKER[2] described a case of congenital, soft, thin-walled tumour, noticed in a female child, two months old. It occupied the centre of the posterior triangle of the neck, was resonant on percussion, rose and fell with respiratory movements; during respiration was quite tense, hemispherical, and as large as a Tangerine orange. It sprang from beneath the sterno-mastoid muscle, and its connections with the trachea and thyroid could not definitely be made out. Its contents were air, and it rose and fell with respiration. Though Parker thought it corresponded with Virchow's ventricular laryngocele, there seems no doubt that it was a tracheocele.

The curious case described by HUTCHINSON[3] is instructive. A pale, phthisical-looking man, twenty-three years of age, presented an evenly-rounded swelling, of the size of a pigeon's egg, over the lower part of the larynx and front part of the trachea, which could be emptied with ease on pressure, and which refilled on coughing. It was tympanitic to percussion, and the base was indurated. The swelling had developed within three weeks, being at first small, then increasing. The voice was hoarse until compression of the tumour with compresses was applied, when it amended. The man was far advanced in phthisis, and Hutchinson inclined to the opinion that the origin of the condition was in laryngeal ulceration.

DAREMBERG and VERNEUIL[4] described an interesting case of a man of good constitution, aged 73, having for many years had a dry cough, and on two occasions suffocative crises. A small tumour was discovered on the left side of the neck, compressing and slightly deviating the trachea, and the tumour appeared to be prolonged behind the clavicle, and was localized in the corresponding lobe of the thyroid gland. The vocal cords moved perfectly, and were healthy. Tincture of iodine

[1] *N. York Med. Record*, April 4, 1885.
[2] Clin. Soc. Trans., vol. XIX.
[3] *Med. Times and Gazette*, March, 1861.
[4] *Revue de Chirurgie*, May 10, 1886.

diminished the tumour. A year after, the small tumour of the size and form of a finger increased during coughing, and diminished afterwards. The right vocal cord was now motionless. There was also some difficulty of deglutition, and hot drinks brought on spasms of coughing, ending in their rejection by the nasal fossæ. The tumour was of the size of a citron, and disappeared suddenly. A smaller tumour appeared on the right side, apparently a dependence of the former. The authors regarded it as arising from sacciform protrusion of the membranous portion of the posterior tracheal wall, leading to hernia between the trachea and œsophagus. At first, the orifice being narrow prevented it from emptying completely and easily, thus giving rise to the formidable attacks of suffocation noticed at first. There was tracheal stricture in this case, and the case finally ended fatally, oppressed breathing passing into aphonia and asphyxia.

GIRAUD'S[1] case of "traumatic tracheocele" is also singular. A woman of forty-one came to the hospital with a transverse wound of the neck, penetrating the skin, sterno-mastoid and scalene muscles, and the external jugular vein. In ten days all had healed, but, at the end of a violent fit of coughing originated by a bronchitis, a soft, extensile, and easily reducible tumour was observed at the left side of the neck, of the size of an orange, appearing during coughing and disappearing while at rest. There was no sonority or crepitation. The symptoms lasted fifteen days, the cough amended, and the tumour had much diminished when the woman left the hospital. Giraud believed it to be caused by the rupture of a cicatrix formed in the trachea as a consequence of the coughing.

HEYMANN[2] demonstrated a case of tracheocele occurring in a child four years old. The author had noticed an intumescence of the neck during speaking and coughing, and every forced expiration brought into view a rounded tumour, which was tympanitic to percussion. Heymann thought that, as the tumour was very slow in filling, the communication between the trachea and the hernia must be small. Chronic catarrh accompanied the condition, and led to hoarseness.

I have only been able to find eleven cases of tracheocele recorded, which, with three cases of my own, will make fourteen in all. Of these, Giraud's and Détis' cases should, perhaps, not be called "tracheocele," if we restrict that term to hernial protrusions of the tracheal membranes.

The etiology of this curious condition is not very definite. So far as sex is concerned, it is three times as common in the male as in the female sex. As to age, it has occurred in a child eighteen months old, in a child eight months old, and in another of four years old, and seems to have been congenital in Parker's case, and, perhaps, also in Heymann's, and one of Faucon's cases. All the other cases have been adults. The causes leading to the appearance of the tumour have been violent expiratory effort, such as coughing, "straining with a closed glottis" (Cohen), or vomiting. In several cases there has been a history of chronic bron-

[1] *Revue de Chir.*, Jan. 10, 1887.

[2] Fifty-ninth Meeting of German Naturalists and Physicians, Laryngological Sub-section. Berlin, September, 1886. See also *Journal of Laryngology*, edited by Mackenzie and Wolfenden. Vol. I., No. 2, 1887.

chitis and tracheitis, attended with more or less coughing, and it may not be unintelligible that such a chronic condition may so weaken the tracheal walls as to lead easily to hernia. In Giraud's[1] case the hernia occurred after coughing, in chronic bronchitis, in a woman who had suffered an incised wound of the neck, in which the trachea had been involved, had subsequently cicatrized, and later on, this cicatrix had been broken by the coughing efforts. Giraud calls this "Traumatic Tracheocele."

The diagnosis of the condition is easily made. A well-defined tumour, situated above the sternum, in front or at the side of the trachea, not as a rule reaching above the cricoid cartilage, soft, elastic, and generally compressible, varying in size from a walnut to a small orange, enlarging during expiratory effort with mouth and nares closed, or with coughing, and diminishing with deep inspiration, should leave no doubt as to its nature. Its inflation can generally be completely or partially prevented by pressure applied to its external surface, and a spot may sometimes be found on the tracheal wall, pressure applied to which completely prevents expiratory inflation of the tumour. The tumour is sometimes tympanitic, though not always; if the wall be thick, respiratory sounds are heard in its interior, and the voice-sounds occasionally have a muffled resonance or "cooing" character. In Eldridge's case, the insertion of a hypodermic needle into the tumour was followed by the exit of a stream of air, forcible enough to extinguish a lighted match. The movements of the vocal cords and the laryngeal muscles have been described by most observers as sluggish, and the larynx as sometimes congested. One cord has also been described as lying motionless, probably from pressure upon the laryngeal nerves by the tumour. Slight dyspnœa generally exists, and severe suffocative attacks may occur, in which tracheotomy may be necessary. The voice is often weak, and most patients have signs of debilitated constitutions.

The most probable condition for which tracheocele would be confounded would be goître. The inflation of the tumour would, however, prevent this error. From emphysema of the neck the condition is readily differentiated, and there can be no possibility of confusing the condition with pulmonary hernia. Very little can be done in the way of treatment. The application of a pad, to compress the tumour, is all that can be advised. Constant pressure, persistently applied, will certainly diminish the tumour. In a few cases the dyspnœa has been so intense as to suggest the propriety of tracheotomy. Heidenreich opened the pouch and endeavoured to promote cure by suppuration, but it is probably true, as Gayet remarked, that every attempt at radical cure will lead to results worse than the condition itself.

The pathology of this condition is most obscure, and several hypotheses have been emitted. I have referred to Virchow's views upon trachectasies and ventricular laryngocele, and to Duplay's idea of extravasation of air into tracheal bursæ. Rokitansky[2] ascribed certain sacciform diverticula of the trachea to hypertrophy and dilatation of the muciparous glands.

Eldridge[3] believed that all the cases of this character were most

[1] *Revue de Chirurgie*, 1887, No. 1. [2] *Path. Anatomy.* [3] Loc. cit.

easily explained on the supposition that blind or incomplete fistulæ of the neck exist, internal and congenital, due to persistence of the branchial clefts, or want of union of the branchial arches in the middle line, but congenital tracheal fistulæ have not yet been proved to exist, and M. Sarazin[1] has shown that the three reported cases of Luschka,[2] Riecke,[3] and Jenny,[4] were either branchial fistulæ or not congenital, and, as is properly remarked in Jacquoud's "Dictionnaire de Médecine" "the branchial origin of these fistulæ is less admissible still, since the branchial arches take no part in the development of the trachea," so that this view which has been adopted by Cohen[5] and Mackenzie[6] cannot any longer be maintained.

Rupture of the trachea has been advanced by some writers as the cause of these tumours, either of the membranous portion of the trachea in the posterior wall, or the membranes uniting it to the larynx, or from ulceration and pathological perforation of the trachea itself with extravasation of air into the peri-tracheal cellular tissue. This theory has latterly been maintained by Giraud,[7] who admits, however, that these cases of congenital tracheocele (Faucon, Devalz, and latterly Parker) must be explained on the ground of "arrest of development.'

Rupture of the trachea, whether from ulceration or other cause, with sudden extravasation of air into the cellular tissue, would give rise to characteristic emphysema of the neck, indicated by ill-defined crepitant enlargements which subside in a few days, and Giraud's case must be regarded as having quite an exceptional origin. The very chronic and slow course of development of these tracheal tumours argues against any such lesion, and rupture into the tracheal bursæ of Duplay, with subsequent distension, must be regarded as still more problematical.

After all, the old and generally accepted idea of a hernial protrusion of the tracheal membranes originating at some weak spot of the tracheal wall, either acquired (as in cases of chronic tracheitis, such as has preceded most of the recorded cases) or congenital, is the most satisfactory.

Tillaux[8] remarked, "The fibrous membrane, very resistant, forms the frame-work of the trachea ; it is composed of connective tissue fibres with a great number of elastic fibres, and this structure permits of the *bizarre* development of gaseous tumours at the sides of the trachea and communicating with its cavity, which are true hernias of the fibrous membrane, produced generally under the influence of violent expiratory effort." It has been objected that the solid adherence of the mucous membrane to the subjacent parts would prevent any hernial distension, but the interesting case recorded by Hutchinson would dispose of this difficulty. Again, Gerhardt[9] very pertinently remarks, "that not only is

1 *Dict. de Méd. et de Chir. Pratique*, 1869, t. IX., p. 659.
2 *Archiv. für Phys. Heilkunde*, 1848.
3 Walthern-Ammon, *Journ. de Chirurgie*, Bd. XXXIV.
4 *Schweizer Zeitsch.*, Bd. I.
5 Ashurst's *Encyclopædia*, vol. V.
6 *Dis. Throat and Nose*, vol. I., p. 537.
7 *Revue de Chirurgie*, Jan. 10, 1887.
8 *Traité d'Anatomie Topographique*, p. 402.
9 *Handbuch der Kinderkrank*, vol. III., Heft 2, p. 564.

this thin, smooth, lax surface ('pars membranacea' of the trachea) prone to malformations, but is easily predisposed to diverticulum formation, by reason of the yieldingness of its slightly resistant muscular fibres and elastic and fibrous tissue." Meckel observed such a diverticulum of the trachea at the level of the fifth and sixth cartilaginous rings directed backwards, and being in communication directly with the trachea by a fine opening. While it must be admitted that the pathology of these conditions is obscure, owing to our want of post-mortem evidence, there is more reason to ascribe them to true hernia of the tracheal yielding membranes (rendered more yielding by pre-existent catarrhs of long standing) than to any other cause. Eldridge's theory of defect of the branchial clefts must be dismissed at once, as founded on erroneous developmental data, and the theory which ascribes them to ruptures of the tracheal wall, though applicable to Giraud's case (which, however, may well have been one of encysted emphysema), cannot be maintained for the majority of cases, such lesions giving rise to quite different conditions, viz., emphysema of the neck. **R. Norris Wolfenden.**

NEW INSTRUMENTS AND THERAPEUTICS.

MAW, SON & THOMPSON (London).—**Balin's Improved Fur-Respirator.** *British Medical Journal, November* 26, 1887.

THIS is a simple contrivance of a piece of natural fur, perforated with fine holes. It is backed with flannel, and makes an effective air filter.

Hunter Mackenzie.

W. W. M.—**Climate for Asthma.** *British Medical Journal, December* 3, 1887.

RECOMMENDATION of Bournemouth, which, though on the sea, is screened from all winds but the south, and is surrounded by pine forests. It consequently presents the principal desiderata for respiratory affections. (We have good reason to know that the east wind is not unknown at Bournemouth.)

Hunter Mackenzie.

CLAY, JOHN (Birmingham).—**On the Treatment of Cancer.** *Lancet, November* 19, 1887.

FOUR cases are recorded illustrative of the successful treatment of cancer by Chian turpentine. One is a case of epithelioma of the tongue, and another is a case of epithelioma of the nose and face.

Hunter Mackenzie.

GREENE, G. (Ferns, Wexford).—**The Local Application of Condy's Fluid in Syphilitic Glossitis.** *Lancet, Nov.* 12, 1887.

RECORD of a case (tertiary) illustrative of the value of this method of treatment, with no internal medication other than stomachics.

Hunter Mackenzie.

RUAULT.—Naptholized Water in Ozæna and Purulent Rhinitis. *Archives de Laryngologie, December*, 1887.

THE author employs nasal irrigations according to the following formula :—

Napthol β	...	12 gr.
Alcohol (at 90°)...		84 ,,

A teaspoonful in a litre of tepid water is employed for irrigation. A disagreeable burning pain is experienced ; it is, however, only temporary. In intolerant subjects it is necessary to use weaker solutions, and to precede the irrigation with cocaine spray. **Joal.**

CHARTERIS, MATTHEW (Glasgow).—**The Climatic Treatment of Phthisis in the State of Colorado.** *Lancet, Nov.* 19 *and* 26, 1887

A DESCRIPTION and recommendation of Colorado for certain forms of phthisis, with illustrative cases. **Hunter Mackenzie.**

HAMBLETON, G. W. (London).—**The Scientific Treatment of Consumption.** *Lancet, November* 26, 1887.

THIS consists of "short notes of the four cases to which reference was made in my paper read before the British Association at Manchester." No details are given regarding this method of treatment.

Hunter Mackenzie.

HOPMAN (Köln).—**Short Remarks on the Question of Large Doses of Creosote in Laryngeal and Pulmonary Phthisis.** *Berlin, Klin. Wochen.*, 1887, *No.* 52.

THE author prescribes creosote and tincture of gentian in equal portions. The patient takes, three times a day, ten to thirty drops in a wine-glass of water. The author is content with the results of this treatment, which he has employed for eight years. **Michael.**

DIPHTHERIA.

DELTHILL.—The Relation of Animal to Human Diphtheria. *Soc. Méd. Pratique, February* 8, 1888.

TRENDELENBURG, Oertel, Gerhardt, and others have inoculated diphtheria in rabbits and pigeons, and Delthill believes in the transmissibility and identity of diphtheria in animals with that of man, taking into account the modification of appearances impressed upon the affection in its receptivity in different classes of animals. He has been able to collect thirteen observations confirming his view, in which the diphtheritic affection appears to have been communicated from fowls and pigeons. He concludes, the identity of diphtheria in man and animals is probable,

its transmissibility from one to the other is possible, and it is probable that diphtheria may be transported to a distance by a third person, he himself remaining unaffected. **Joal.**

COOPER, FRANCIS, and WILKS, Rev. W. (Shirley).—**Diphtheria and Main Drains: the Outbreak at Shirley.** *British Medical Journal, November* 26, 1887.

A LETTER to the Editor, in which an outbreak of diphtheria is attributed "to the sewer gratings level with the road, the stench from which at times is, beyond all contradiction, most pestilential." (In a subsequent note to the Editor, Dr. Alfred Carpenter disputes this view.)

Hunter Mackenzie.

BARRETT, ALFRED E. (London).—**Diphtheria Circumscripta, or Sandringham Sore-throat.** *British Medical Journal, Nov.* 26, 1887.

THE author thus describes the throat appearances:—"A circumscribed patch, mostly on one tonsil only; from this, as from a centre, a low form of inflammation spreads into the surrounding parts, causing swelling sometimes as far as the angle of the jaw; this swelling gradually increases for about ten days, when, in favourable cases, the slough separates, leaving a clean red sulcus, when the swelling gradually subsides. During convalescence, which is tardy, paralysis occurs in a considerable number of cases. In fatal cases death occurs from asthenia, sometimes preceded by convulsions; all the other essential symptoms of ordinary diphtheria are present, but the slough or exudation does not spread, but remains circumscribed throughout, and there is no tendency to suppuration."

Hunter Mackenzie.

MAY, PARKER G. (Maldon).—**The Treatment of Diphtheria.** *British Medical Journal, November* 26, 1887.

THE employment of gargles is considered pernicious. For local application, brushing with a combination of carbolic acid, sulphurous acid, perchloride of iron, and glycerine. Internally, a mixture of carbolic acid, tincture of the perchloride of iron, sulphurous acid, chlorate of potash, and glycerine. Nutritious diet, and occasionally the cautious use of wines. When hæmorrhage from the nose or throat occurs, the administration of turpentine in the form of emulsion appears to be of use. (This treatment ought to contain the elements of success). In a note in the *B. M. J.* of December 3 it is stated that the mixture recommended by Dr. Parker May does *not* contain carbolic acid. **Hunter Mackenzie.**

ROULIN.—Treatment of Diphtheria by Phenol Douches. *Soc. Méd. Pratique, January* 5, 1888.

THE author gives a statistical *résumé* of seventy-nine cases in which he has successfully employed this treatment, and concludes that diphtheritic angina, whatever its gravity, whatever the ages of the patients, can and ought always to be cured by phenol treatment; that the time of cure varies between two and twenty-three days, with an average period of five days; that the treatment is applicable to every patient without distinction under the form either of douches, gargles, or swabbings: that it succeeds in every stage of the disease; and that it prevents the invasion of the

larynx by false membrane. In confirmed croup it is necessary to add to the medication emetic treatment. **Joal.**

GAUCHER.—On a Method of Treatment of Diphtheritic Angina by Ablation of the False Membranes, and Antiseptic Cauterization of the Subjacent Mucous Membrane. *Archives de Laryngologie, December*, 1887.

ONE finds it everywhere stated that diphtheria is a generally infectious disease. There is much in favour of the view that it is a general disease at the onset. The author, who has been one of the distinguished *internes* of the Hôpital des Enfants, contests this latter view. Diphtheria is at first local, afterwards becoming generalized, but it is not a constitutional infection at the onset. Moreover, if the angina is the first condition of the disease, if it is the source of infection, it should be treated with the greatest energy, for in destroying the false membrane one removes the cause of the general infection which is to be expected. The author holds the opinion that a simple diphtheria exists without any constitutional infection, and that the place of local infection may be other than the pharynx, according as the infectious germ is implanted on the mouth, larynx, bronchi, or skin. Gaucher, by energetic friction, removes mechanically the false membranes by means of a brush saturated with the following solution :—

Oil, 15 gr.
Alcohol (at 36°), 10 gr.
Camphor, from 20 to 30 gr.
Phenic acid, from 5 to 10 gr.

He employs the weakest solution in benign cases. The operation is repeated night and morning, and in the intervals of cauterization the throat is irrigated every two hours with phenic solution (1 in 100). The pretty severe pain produced by cauterization may be diminished by cocaine sprays, 2 to 3 per cent. Since 1879 the author has treated in this manner sixteen cases of severe diphtheritic angina, all of which have been cured. **Joal.**

RUHEMANN.—Case of Ataxia following Diphtheria in a Boy of Eight. *Berlin. Klin. Wochenschr.*, 1887, *No.* 49.

THE title explains the contents. **Michael.**

NOSE AND NASO-PHARYNX.

JARVIS, W. CHAPMAN.—Two Unique Cases of Congenital Occlusion of the Anterior Nares. *New York Medical Journal, November* 12, 1887.

A DESCRIPTION of two cases treated by the author's nasal drills and an electric motor. In the first case the left anterior naris remained patent after the first operation. A second was performed on the right nostril, with a considerable measure of success. In the second case there was a

congenital abnormality of the bones of the face, associated with marked malformation of portions of the anterior nasal framework, especially the inferior turbinated bones. A channel was made with the author's rongeur forceps, but this contracted in a very short space of time, and a second operation was declined. **Maxwell Ross.**

DELAVAN, BRYSON.—On the Ætiology of Deflections of the Nasal Septum. *New York Medical Journal, November* 12, 1887.

IN discussing the influence of race, the writer says that in the course of studies made on many thousands of specimens in America and Europe he has found: (1) That among European races deflections of the septum are of common occurrence, 50 per cent. of all specimens showing a greater or less degree of deviation. (2) Of the different nationalities of Europe at the present day, the highest proportion of deformed septa is found among the Sclavonic and Hebrew races. Thus, skulls of Russians, Bohemians, Poles, and Hungarians, are more apt to show deflected septa than those of the Germanic, Celtic, and Norman types. (3) In the anthropological collection of the Peabody Museum, at Cambridge, Mass., is a cabinet containing eighteen well-preserved specimens of skulls taken from ancient Roman tombs. Among these there is hardly a single instance in which the septum is straight, while in seven the degree of deflection is excessive, and far beyond that usually seen. Thus, the aquiline type of nose, as illustrated in the Sclav, Hebrew, and ancient Roman, is particularly apt to be associated with deflection; but as a set-off to this the type found by the author to be freest from deformity of the septum is the American Indian, in whom the aquiline nose is characteristic. **Maxwell Ross.**

JALAQUIER AND RUAULT.—Polypus of the Right Nasal Fossa, depending into the Nasal Pharynx; Cephalagia, Neuralgic Pains, Excessive Nervous Irritability; Extirpation of the Tumour *per vias naturales.* **Cure.** *Archives de Laryngologie, December*, 1887.

THE title indicates the nature of the case. **Joal.**

CHATELLIER.—Hypertrophy of the Nasal Mucous Membrane. *Soc. de Biologie, January* 31, 1888.

A HISTOLOGICAL examination was made in a case in which the nasal mucous membrane was thickened, its appearance mammilated and muriform, particularly at the posterior extremity of the inferior turbinated bodies. The tissue much resembled that of mucous polypi, and amongst the cellular elements were seen:—1. Migratory corpuscles. 2. Connected tissue corpuscles, some with single nucleus, others larger, star-shaped, and containing several nuclei. Between these cells numerous interlacing fibres occurred, disposed without order, and non-fasciculated, of the nature of which the author was not certain. **Joal.**

WOOLEN, G. V.—A Rare Case of Hypertrophy and Polypus of the Naris. *Indiana Medical Journal*, 1887.

A TUMOUR, reaching half an inch below the margin of the right velum, was found. It proved to spring from the right inferior turbinated body,

and to be a true hypertrophy of the normal tissues. A large polypus also presented anteriorly in the middle meatus of the right side. The latter was removed first, and a third mass was removed from the posterior naris. The first-mentioned mass was afterwards removed with Hobby's curved canula écraseur. When this was removed, a large polypus attached to the right middle turbinated body dropped down. It was twisted off at the pedicle by dressing-forceps. The posterior portion of the right middle turbinated body was also enlarged and polypoid, and was removed with the snare. The author justly remarks that it was wonderful that so much material could be contained in the cavity of one naris. Very few and insignificant subjective symptoms existed, and no reflexes. **Wolfenden.**

CHEATHAM, W.—Nasal Reflexes as Cause of Diseases of the Eye. *Amer. Pract. and News*, 1887.

A CASE of hypermetropia and presbyopia in a woman of forty-five, cured by removal of nasal polypi and reduction of engorged nasal membranes.

A second case, of myopic astigmatism corrected by glasses, in which the patient was unable to study by reason of pain in the eyes. Acute coryza, deflected septum, and engorged inferior turbinated body blocked the left side; the right side was also blocked by inferior turbinated engorgement. Reduction of these by galvano-cautery and chromic acid enabled the patient to return to his studies.

A third case, in which there was pain in the left eye, and both nares were filled with polypi, especially the left. Removal of these cured the condition.

The author frequently meets with conjunctivitis and keratitis which do not yield to treatment until existing nasal catarrh or eczema is relieved.

Cases of glaucoma relieved by stretching the nasal branch of the fifth nerve are thought by the author to be probably the result of chronic nasal disease. The author has had two cases of acute conjunctivitis the result of teething.

The author feels confident that many cases of asthenopia will be cured by treatment directed to the nose. **Wolfenden.**

CHEATHAM, W.—Hypertrophy of the Third (or Pharyngeal) Tonsil, with an interesting Case. *American Practitioner and News*, 1887.

A CASE occurring in a young man of nineteen, who had never been able to respire through the nose, but who gained complete comfort after removal of the growths. The author remarks that children do not bear cocaine well, and because of hæmorrhage, which always attends the operation, general anæsthesia cannot be resorted to. All that we can do in these cases is to remove the tissue piecemeal by an operation once every two or three days. The author sometimes scrapes with the finger, or curette, or with the forceps. In the case related by the author the growths were torn away with the finger. [We do not agree with the author in his remarks as to the treatment of these growths in children. It is our

invariable custom, at the Throat Hospital in London, to put even young children under anæsthetics, and remove the growths at one operation. Young patients cannot be got to tolerate frequent operations, and it is only in intelligent young adults, from whom assistance may be obtained, that the use of curettes or instruments without anæsthesia is admissible. Though there is much hæmorrhage, there is less in the operation with the post-nasal forceps, under anæsthesia, than in scraping with the curette, with or without anæsthesia. The advantage of the post-nasal forceps and anæsthesia is that one operation suffices ; but this is rarely the case with the curette, or without anæsthesia.] **Wolfenden.**

KILLIAN (Worms).—**Contribution to Empyema of the Antrum of Highmore.** *Monatsschr. für Ohrenheilk.*, 1887, *Nos.* 10 *and* 11.

A GOOD review of the subject, containing nothing original. **Michael.**

MOUTH, TONSILS, PHARYNX, &c.

DAVID.—Aphthous Stomatitis and its Origin. *Archiv. Gen. de Médecine, October*, 1887.

FROM this excellent essay one may conclude :—1. That there is a striking analogy between a disease of human beings and a contagious disease of domestic animals. 2. That there are facts, some of which are very striking, to prove transmission from the bovine or ovine species to mankind by direct contact through milk. 3. That there are contagious diseases among cattle, and simultaneous epidemics, which progress in a parallel manner. 4. That there was at least one case of aphthous fever in a goat infected by children suffering from aphthous stomatitis. 5. A decisive instance, in which stomatitis developed three or four days after using the milk. 6. That aphthous stomatitis of man and of animals are one and the same disease, transmitted to man by domestic animals, principally through the agency of milk. **Joal.**

SCHLIFEROWITSCH. —On Tuberculosis of the Mouth. *Deutsch. Zeitschr. für Chirurgie, Bd. 26, Heft 5 and 6.*

FROM his own observations, and from collection of the cases recently published, the author endeavours to prove that there is a primary tuberculous affection of the mouth, and that this must be treated surgically. After an historical discourse, he insists that a primary affection can easily arise from infection of the place. He then relates the following cases :—

(1.) Tubercular disease of the under lip combined with tuberculosis of the joints and of the lung. Syphilis was excluded by antisyphilitic treatment. Death. Post-mortem examination.

(2.) Tubercular ulcer of the tongue. Extirpation with the Paquelin cautery. Cure.

(3.) Tubercular ulcer of the tongue, combined with pulmonary phthisis.

(4.) Tubercular ulcer. Cured by extirpation with the Paquelin cautery.

(5.) Tubercular ulcers of the tongue. Cured with the Paquelin cautery.

(6.) Ulcers on the gingiva. Cured with galvano-cautery and tincture of myrrh.

(7.) Phthisical patient, with tubercular ulcers of the tongue. Cured with the Paquelin cautery.

(8.) Multiple tubercular ulcers in the mucous membrane of the mouth, with pulmonary phthisis. Death.

(9.) Tubercular ulcer of the lip. Pulmonary phthisis. Death.

(10.) Tubercular ulceration of the alveoli of some teeth. Treatment with the sharp spoon. Improved, but not yet cured.

(11.) Tubercular ulcers of the tongue. Excision with the Paquelin cautery. Cure.

(12.) Tubercular ulcers of the mucous membrane of the mouth and of the larynx. Death. Post-mortem examination.

Then follows a collection of the recently published cases. The differential diagnosis must be made from carcinoma and syphilis. The first can be excluded by antisyphilitic cures, the latter by the bacilli and by the pulmonary phenomena. The pains are also not so severe as in carcinoma. The progress depends on the general health of the patient. The treatment must be energetically surgical. **Michael.**

GLEITSMANN, J. W.—Hypertrophy of the Tonsil of the Tongue. *Medical Record, December* 17, 1887.

THE lingual tonsil, like that of the Eustachian tube, has not a circumscribed form, and contains follicular glands in the disseminated form. In certain cases these glands assume a well-defined shape. They are not true glands, having no outlet, are closed, and belong to the lymphatic system. They are loosely imbedded in the sub-mucous tissue, the hilus is covered by thin mucous membrane, and the sac contains a number of follicles, closely resembling Peyer's patches. They are located between the circumvallate papillæ and the epiglottis, and appear at the age of puberty. The causes leading to hypertrophy are probably the same as those leading to hypertrophy of the faucial tonsil. The author refers to Swain's, Clarence Rice's, and H. Curtis's observations, as illustrating how the condition may give rise to spasmodic cough, and may influence the singing voice. Patients also complain of the sense of a foreign body or pressure in the throat; of interference with singing or speaking; of pain; of cough; and of asthmatic attacks. The first is the most frequent symptom. Quite a number of cases of globus hystericus may be explained by hypertrophy of these glands. Fatigue of the voice is common, even aphonia. The voice loses its clearness in some, and in others it breaks suddenly during singing. Others complain of pain in talking, without hoarseness. Sub-acute inflammation sometimes occurs, causing actual pain; and this may radiate to the ears, or be located between the shoulder blades, the larynx, trachea, or stomach.

Spasmodic cough is less frequent than a hacking cough. Before decid-

ing upon the nervous origin of some asthmatic attacks, the absence of hypertrophy of these glands should be assured. The author relates four original cases. The author employs Lugol's solution of different strengths: nitrate of silver fused on to a probe; the galvano-cautery; the snare. He cannot speak favourably of Lugol's solution, and only employs it when the cautery is objected to. He praises repeated scarifications with the galvano-cautery, and the use of the snare when the mass is lobular. The cautery is preferable, is not more painful, and, creating a larger slough, is more thorough. Care should be taken not to wound the epiglottis. **Wolfenden.**

ROBERTSON, WILLIAM (Newcastle-on-Tyne).—**Hypertrophy of Lingual Tonsil.** *British Medical Journal, November* 19, 1887.

NARRATION of a case treated by the application of the galvano-cautery. (It would have been well if the *after results* of treatment in this case had been fully given.) **Hunter Mackenzie.**

SAVILL.—Epithelioma of the Œsophagus, with Gangrene of the Lung. *Soc. Anatomique. January*, 1888.

THE author presented to the Society a case of epithelioma, which had completely perforated the œsophageal wall, and which seemed at first to have invaded the lung. Histologically, it was proved that the pulmonary affection was gangrene. M. Cornil, the President of the Society, remarked that he had observed facts of the same kind, and that the gangrene was to be attributed to the action of micro-organisms swallowed with the saliva and the food. **Joal.**

EGLINTON, GEO. W. (Dalton-in-Furness).—**Swallowing Artificial Teeth.** *Lancet, November* 5, 1887.

THE patient was ordered to eat a few figs and take an emetic. Shortly afterwards the teeth, imbedded in the figs, were vomited.

Hunter Mackenzie.

J. B. E.—Passage of Foreign Bodies through the Alimentary Canal. *Lancet, November* 5, 1887.

A BABY, eight months old, swallowed the screw and clip for compressing the tube of a feeding-bottle, and passed them *per anum* eighteen hours afterwards. **Hunter Mackenzie.**

GROOM, WILLIAM (Wisbech). — **Passage of Foreign Bodies through the Alimentary Tract.** *Lancet, November* 12, 1887.

A CHILD, aged two and a half years, swallowed a shilling in June, 1887. "In October he had a violent attack (!), and with it brought up the lost shilling, which was much discoloured and corroded."

Hunter Mackenzie.

CADET DE GASSICOURT.—Pultaceous Angina an Initial Symptom of Typhoid Fever. *Soc. Méd. Pratique, January* 8, 1888.

THE author publishes three cases which establish the difficulty of diagnosis of typhoid fever when it commences with this form of angina. In the

first case it was thought that that was simply an herpetic sore-throat, in the second scarlatinal, and in the third diphtheritic angina. It was only when the temperature and consecutive symptoms demonstrated the true nature of the case, that it was evident that the enteric fever had commenced by way of the throat. **Joal.**

KOCH, PAUL.—Remarks on Paræsthesia of the Upper Air-passages. *Annales de Mal. de Larynx, &c., November*, 1887.

PARÆSTHESIAS differ from hypæsthesias and anæsthesias in that sensibility exists, and it is often exaggerated ; they differ from hyperæsthesias and hyperalgesias in representing anomalies of physiological characters of sensation, and because their intensity is never proportional to the exciting cause. Spontaneous, so to say, or at least emanating from a cause which may be internal or external, but always minimal, and sometimes illusory, paræsthesias are the expression of internal extraordinary sensations often fantastic, their intensity and character never corresponding to lesions which can be defined. Pharyngeal and laryngeal paræsthesias occupy the first rank in the series of neuroses of sensibility, those of taste and smell may constitute one of the first symptoms of locomotor ataxy. Statistics of paræsthesias of the upper air-passages teach us that in hysterical and neurasthenic patients paræsthesias are manifested in an acute form ; on the contrary, in hypochondriacal persons these neuroses appear in a chronic form. If these laryngeal and pharyngeal paræsthesias can exist outside of any palpable lesions of the upper air-passages, one may often find them dependent upon pathological states of other organs distantly situated. The principles established for the origin of reflex neuroses proceeding from nasal affections are equally applicable to the mouth, pharynx, larynx, or bronchi.

This memoir contains numerous original observations, and will well repay study in the original. **Joal.**

IVERSEN, AXEL (Copenhagen).—**Resections of the Pharynx and the Œsophagus (including in some cases Extirpation of the Larynx.** *Nordiskt. Medicinskt. Arkiv. Vol. xix.* 3, 1887.

THE author first gives an account of the further course of six cases of this operation, described by him before in Langenbeck's Archiv, vol. xxxi., 3. The first of these was that of a woman aged thirty-four, with carcinoma of the pharynx ; she died six months after the operation from a local recurrence of the growth ; the second patient, a woman aged fifty-one, died nine months after the operation ; and the third, a woman aged forty-eight, died four months after the operation, both from local recurrence. The fourth, a woman aged fifty-six, who was operated on for a cicatricial stricture of the gullet, is living still in good health. The fifth patient was a woman aged forty-four, with carcinoma of the pharynx, in whom also the whole larynx was removed ; she died thirteen months after the operation from septicæmia, arising from a small operation performed on the trachea, to extend the opening for the canula ; the post-mortem examination did not show any recurrence. The sixth case was that of a woman aged forty-eight, in which also the whole larynx was

removed ; the patient had a recurrence of the growth thirteen months after the operation, but died from septic pleurisy caused by her perforating the œsophagus herself with the feeding tube, pouring the liquid food down into the right pleural cavity. The post-mortem examination showed that the lower part of the *œsophagus was extremely atrophied* (from disuse) *the walls being as thin as paper*, and the ominous fissure caused by the feeding-tube was found four centimetres under the arcus aortæ.

In all the cases described before, as well as in four fresh ones, the operation was performed through subhyoid pharyngotomy preceded by deep tracheotomy. When the pharyngeal growth, which in most cases is situated very low, extending also to the upper part of the œsophagus, is more or less circular, occupying also the posterior surface of the larynx, Dr. Iversen makes a long vertical incision in the middle line down from the transverse subhyoid incision, and also removes the whole larynx, partially to make the operation as radical as possible, and partially because it is difficult to remove the growth radically without lesion of the recurrent nerves, which, when put out of function, render the larynx useless to the patient. The author lays great stress upon performing the tracheotomy as deep as possible, so that there is a broad bridge of skin between the opening for the tracheal canula and the opening to the large wound ; he also advocates strongly the use of iodoform gauze in dressing the wound. Space does not allow us to enter into further details of the operation, which appears to have been performed with great surgical skill, and we must refer readers wanting further information to the original articles.

Of the four fresh cases never described before, the first was a woman aged forty-nine, who about eleven months previously had begun to suffer from difficulty in deglutition. There were swollen glands in both lateral regions of the neck, and the patient exhibited a cachectic appearance. The lower part of the pharynx and the upper part of the œsophagus were occupied by a carcinomatous growth (shown microscopically to be epithelioma) ; the larynx only showed slight congestion and tumefaction. In this case, the diseased parts of the pharynx and the œsophagus, the whole larynx, and the left lobe of the thyroid gland were removed. The patient died thirty-seven days after the operation from multiple bronchopneumonias and small abscesses in both lungs.

The second new case was that of a woman aged twenty-seven, whose symptoms had only lasted two months. In this case the cancer (shown microscopically to be epithelioma) also occupied the posterior surface of the cricoid cartilage, the lower part of the pharynx, and the upper part of the œsophagus. Besides slight general congestion of the larynx, there was found, by laryngoscopical examination, slight œdematous swelling over the right arytenoid cartilage. The operation was performed as in the former case, the whole right lobe of the thyroid gland being besides removed. She died thirty hours after the operation from collapse. No post-mortem examination was allowed.

The third fresh patient was a woman aged forty-six, who had felt the first symptoms half a year previously. In this case the growth, which

was shown microscopically to be an epithelioma, extended to the right arytenoid cartilage on the right ary-epiglottic fold. By the operation the lower part of the pharynx, the upper part of the œsophagus, and the whole larynx were removed, but it was not possible to reach the lower edge of the growth in the œsophagus. The patient died eight days after the operation. The post-mortem examination showed parenchymatous degeneration of the organs (septicæmia? iodoform-poisoning?).

The last case was that of a woman aged thirty-four, symptoms having lasted four months, with epithelioma (microscopical diagnosis) beginning at the height of the epiglottis, and reaching so far down that the lower incision by the operation was made at the level of the first dorsal vertebra; besides the whole larynx, a part of the left lobe of the thyroid gland was removed. The laryngoscopical examination showed the larynx entirely free from any symptoms. The patient is living still (February, 1888), fourteen months after the operation, and is doing well.

It will be seen that all the patients were women between the ages of twenty-seven and fifty-one. In all the four new cases not described before, and in most of the other cases, the growth was situated low down in the pharynx. It seems to be difficult to determine how far down in the gullet the growth extends, the examination with tubes giving unreliable results. Inspection through the mouth and external examination of the neck often do not seem to give any result; sometimes, however, the larynx is more prominent than normal. Swelling of the glands of the neck seems to occur late. Examination by the laryngoscopical mirror and digital exploration are the most important diagnostic means. The symptoms were very marked: dysphagia, pains in the throat, often irradiating to the ears, expectoration of mucus and blood, and emaciation.

Holger Mygind.

LARYNX.

SYMONDS, CHARLES J. (London).—**Intubation of the Larynx: A Summary.**—*British Medical Journal, November* 19, 1887.

CONTAINS nothing but what has already been submitted to the readers of the Journal. **Hunter Mackenzie.**

PARKER, RUSHTON (London).—**Case of Partial Excision of the Larynx, Pharynx, &c., for Epithelioma: Eventual Death.** *British Medical Journal, November* 19, 1887.

THREE recurrences of the disease took place within six months. The author concludes by saying "it would have been better, I think, to have excised the entire larynx the first time, but I was then anxious to avoid unnecessary mutilation, but instead had to inflict probably more."

Hunter Mackenzie.

EDITOR OF BRITISH MEDICAL JOURNAL.—Excision of the Larynx for Malignant Disease. *British Medical Journal, November* 19, 1887.

A LEADING article dealing with the position of this operation at the present day. "Altogether, excision of the larynx is a gloomy subject to contemplate. (In carcinoma) as a rule, it appears to mean death ; as an exception, it signifies a short but harassed lease of life, with constant fear of recurrence and of lung complications." **Hunter Mackenzie.**

STOERK (Wien).—**Extirpation of the Larynx for Carcinoma: Communication of a Successful Case, with Restitution of Normal Respiration and Phonation.** *Wiener Med. Wochenschr.*, 1887, *No.* 50.

THE patient had been operated upon in 1873 for papillomata of the larynx. In 1885 he returned with a carcinoma. Tracheotomy had been performed some years previously. Stoerk extirpated, having tamponned the trachea, and removed the larynx, leaving the posterior wall and the epiglottis. The wound was filled with iodoform gauze. The patient could swallow afterwards, and breathed by an artificial larynx. But the laryngeal canula had to be removed after a short time. Now two new bands of mucous membrane exist, by which the patient can speak well. The tracheal canula is now closed. **Michael.**

SOLIS-COHEN, J.—The Appearance of a Larynx nearly Twenty Years after the Extirpation of an Epithelioma by External Access. *Medical News, December* 3, 1887.

IN 1868 the author removed a large portion of the left vocal band, and the entire lining membrane of the left ventricle, together with masses of morbid growth, portions of which, removed endolaryngeally, had been pronounced epithelioma, by competent microscopists. Tracheotomy was performed, the larynx opened, the growths removed with cutting forceps, the lining membrane of the ventricle scraped out, and the raw tissues seared with acid nitrate of mercury ($33\frac{1}{3}$ per cent.). Some months later, there being no recurrence, the tracheal canula was removed. In 1879 the author, remarking upon the case in his treatise on Diseases of the Throat, intimated that as the patient had remained so long without recurrence it could not have been epithelioma. A suitable locality was prescribed for the patient to dwell, where he would be free from laryngitis. A few weeks ago the patient called upon the author hoarse with laryngitis, which was speedily relieved. Diagrams of the larynx are appended to the paper to show the present condition. Compensatory tissue does service for the left vocal band, formed from the inferior wall of the ventricle, which has been in great measure obliterated by the eversion. The author believes that much of the success of the case was due to the active scraping of the ventricle.

Wolfenden.

MEISER (Berlin).—**Removal of Endolaryngeal Tumours.** *Inaugural Dissertation, Berlin*, 1887.

An essay on the question whether such tumours should be removed extra- or intra-laryngeally. The author prefers, in most cases, the extra-laryngeal method, and communicates one case of polypi of the left vocal band removed by laryngotomy. **Michael.**

EDITORS OF LANCET (London).—**Cancer.** *Lancet, Nov.* 26, 1887.

An editorial article, having special reference to cancer of the larynx, and which contains nothing new. **Hunter Mackenzie.**

WAGNER, CLINTON.—The Surgical Treatment of Six Cases of Cancer of the Larynx. *New York Medical Record, Nov.* 26, 1887.

Tracheotomy was performed in two cases; the epiglottis, which alone was affected, was removed through a subhyoidean incision in a third, and in three other cases tracheotomy, followed by thyrotomy and eradication of the growths, was done. In these four attempts to eradicate the disease, there was a recurrence, and in one of the four the right half of the larynx was removed. Death took place in all of them, at dates varying from three months to two years after the performance of the first operation.

Maxwell Ross.

NEWMAN, DAVID.—Observations on Seven Cases of Cancer of the Larynx. *Glasgow Medical Journal, February*, 1888.

Four of the cases are new. Three are continuations of cases previously recorded. One of the latter had, in January, 1886, first, tracheotomy, and a fortnight later a complete laryngectomy performed. After recovery an artificial phonatory apparatus was worn, and for some months the patient enjoyed very good health, adding two stones to his weight during the summer. At the end of the year a suspicious swelling was observed below the angle of the jaw on the left side. There was no other evidence nor symptoms of recurrence till Midsummer of 1887, when it was found that the swelling had softened, and a cyst had formed, from which were removed seven ounces of dark brown fluid, containing numerous fatty, irregularly shaped epithelial cells. Some relief followed the evacuation, but the swelling in the neck increased, causing difficulty in swallowing. Emaciation commenced and progressed rapidly. Death occurred from exhaustion on November 2, 1887, twenty-one months after laryngectomy was performed. So far as could be ascertained, there was no recurrence of the tumour in the throat, nor evidence of involvement of internal organs. [It would appear from this that an autopsy was not obtained.] The author strongly recommends the performance of a total or partial laryngectomy in all cases of intrinsic malignant disease of the organ, if the diagnosis has been made sufficiently early in the course of the case to admit of its being hopefully carried out. **Maxwell Ross.**

DEFONTAINE. — Inter-crico-thyroid Laryngotomy. *Pratique Médicale, October* 11, 1887.

The author holds, with Chauvel, Marchand, Gosselin, and Gougenheim that inter-crico-thyroidean laryngotomy should not be performed in the

case of old men, children, and in certain affections of the larynx in which there is ossification of the cartilages. On the other hand, the operation is preferable to tracheotomy when extension of the head brings on asphyxia, when there is only a small distance between the cricoid and the sternal fourchette, when the vascularisation of the neck is considerable, or the trachea deep. **Joal.**

ZURLLINGER (Wien).—**Clinical Researches on the Etiology of Chorditis Vocalis Inferior Hypertrophica.** *Wiener Med. Wochenschr.*, 1887, *No.* 57.

AFTER having reported the different views held on this subject, the author refers to the following case. A woman, aged thirty-two, had an infiltration of the soft parts of the nose. The infiltration was hard like stone, and characteristic of rhino-scleroma. There was also infiltration of the arcus palato-pharyngei and the uvula. There was also a tumour under the left vocal band, which caused aphonia. Half a year later the tumour had disappeared. **Michael.**

CADET DE GASSICOURT.—The Dangers of Employing Chloroform in Tracheotomy. *Soc. Méd. Pratique. November* 3, 1887.

THE author is a strong opponent of chloroform anæsthesia in tracheotomy, and cites a new fact in support of his opinion. A child with œdema glottides was tracheotomized, the first time without chloroform. Fifteen days after, a fresh tracheotomy becoming necessary, chloroform was administered, resulting in the death of the patient. **Joal.**

CRAWFORD RENTON, J. (Glasgow).—**Case of Tracheotomy.** *Lancet, November* 12, 1887.

A CHILD, aged seventeen months, presented symptoms of laryngitis, which gradually became so intense as to necessitate tracheotomy. The child progressed favourably for three days, when death followed the bursting of an abscess into the trachea. After death, a sharp and prominent projection was noticed on the left side of the neck an inch below the outer side of the wound. On cutting into the projecting part, a pin was found about two inches in length. The pin, it appears, had been swallowed about three months previously (no history of this had been given to the author), had lodged in the œsophagus, and formed an abscess, which first pressed upon, and finally burst into, the trachea. The author points out that this case "illustrates the importance of bearing in mind the possibility of foreign bodies in the larynx, trachea and œsophagus, producing spasm and difficulty in breathing, even when there is no history of such being swallowed to guide us."

Hunter Mackenzie.

SIMON, R M. (Birmingham).—**Foreign Body in the Right Bronchus; Tracheotomy; Recovery.** *British Medical Journal, November* 26, 1887.

AFTER tracheotomy, the introduction (into the trachea) of an oiled feather was followed by a violent expiratory effort, and the expulsion of the foreign body (a damson stone). The attacks of dyspnœa which

occurred before the operation were attributed by the author to the coughing up of the stone to the glottis. In such cases he considers it best to perform tracheotomy at once, rather than to wait until the foreign body is imbedded in mucus, and fixed by inflammatory action.

Hunter Mackenzie.

BERNARD.—Note on a Case of Tracheotomy performed for Croup under Chloroform. *Progrès Médical, October* 1, 1887.

FROM the success obtained in a case of croup, the author draws the following conclusions:—1. Chloroform anæsthesia induced previously to tracheotomy in croup instantly ameliorates the asphyxia, which generally calls for surgical interference. 2. It enables the surgeon to operate with slowness and security in the most difficult and urgent cases, and probably even without assistance. 3. The anæsthetic can be administered in large doses, by the method of St. Germain, in case of resistance of the patient. 4. Deep narcosis in no way destroys the reflex sensibility of the tracheal mucous membrane. 5. If, in the human being, irritations of the skin of the neck provoke by inhibition a more or less extensive anæsthesia of the integument, this condition does not extend to the deeper parts, whatever may be the opinion advanced by Brown-Sequard on the subject. 6. Chloroform anæsthesia is without effect on the ulterior progress of diphtheria.

ZUCKERKANDL (Graz). **—On Asymmetry of the Larynx.** *Monatsschr. für Ohrenheilk.*, 1887, *No.* 12.

THIS asymmetry is not caused, as Luschka believes, by wearing stiff collars or by traumatic influences, but by an unequal development of the two sides. Not only is the external configuration changed, but there are also internal differences between the two sides. This condition is of forensic interest, because cases might occur in which the question might arise as to the probability of its being caused by strangulation.

Michael.

SOLIS-COHEN, J.—Phonatory Pneumatic Distension, or Hernia, of the Laryngeal Sac. *Medical News, December* 17, 1887.

A CASE of stenosis, due to cicatricial adhesions, had been overcome by intra-laryngeal means. Phonation took place by the use of the ventricular bands. Within a few months the vocal bands became approximated normally in phonation; but if the effort was continued, the bands were forced together, and the sac of Hilton on the left side suddenly bulged forward with an audible jerk into the interior of the larynx, presenting such a picture as if the hyoid bone had undergone dislocation. In another second, the right sac was thrust forward similarly, though less violently. The sac of the left side looked like a globular tumour, the size of a small cherry, paler than the rest of the larynx by reason of distension.

Wolfenden.

ROE, LEGGE A.—Paralysis of the Abductors of the Vocal Cords. *Lancet, November* 12, 1887.

A RECORD of two cases. The second case appears to have existed for twenty years without calling for operative interference—at any rate, the

author was unable to find any cause for the paralysis other than an attack of laryngitis twenty years previously. When last seen the respiration was comparatively quiet. **Hunter Mackenzie.**

GLEITSMANN, J. W. (New York).—**Traumatic Hæmatoma of the Larynx.** *New York Medical Record, October* 29, 1887.

HÆMORRHAGES from the larynx, produced by undue exertion of the voice, or preceded by catarrh, are not uncommon. Injuries of the larynx followed by bleeding, are, in most cases, the result of severe lesions. A traumatic origin is unusual. In the author's case the patient received a blow from a fist upon the larynx, and immediately began to spit blood, lost the power of speech, and experienced severe pains about the larynx. Blood-spitting continued, and deglutition was painful. There was no fracture of the laryngeal cartilages, but a dark red tumour of the shape of a tongue was observed by the laryngoscope, originating by a broad base on the outer part of the posterior laryngeal wall, covering the right arytenoid and extending over the inter-arytenoid space. The extravasation was beneath the mucous membrane.

The left side of the larynx was normal. The right ventricular band formed an indistinct dark red body, almost covering the vocal cord, and no trace of a ventricle could be discovered. The condition readily subsided under treatment of resolvent and slightly astringent sprays. The interesting feature of the case was the simultaneous extravasation of blood into the external posterior as well as the interior right part of the larynx.

The blow appeared to have caused a fissure of the mucous membrane at the posterior external surface of the right arytenoid, causing hæmorrhage, and the larynx being contused against the spine, an extravasation into the aryepiglottic fold resulted. **Wolfenden.**

M. B.—Laryngeal Spasm with Associated Nerve Symptoms. *Lancet, November* 19, 1887.

THE writer asks for suggestions for the treatment of the case of a healthy woman, aged twenty-five, married, who from the age of sixteen has been subject to sudden seizures of difficulty in breathing almost amounting to complete asphyxia, without loss of consciousness, but with the development of urticariæ. Recovery usually takes place in from twenty to thirty minutes. (This elicited a recommendation of inhalations of amyl.)

Hunter Mackenzie.

NECK, &c.

EDITORS OF LANCET (London).—**Exophthalmic Goitre.** *Lancet, November 26*, 1887.

AN editorial note, having reference to the associations of morbid conditions in this disease. **Hunter Mackenzie.**

VETLESEN, H. Y. (Hamar, Norway).—**Etiological Researches concerning Goître.** *Christiania*, 1887.

THIS interesting essay is based on observation of 117 families, in which one or more member suffered from goître; all patients observed living in the town of Hamar and its environs, where the disease is frequently met with, without being endemic. Nearly all the patients examined exhibited the disease only in its lesser forms, and the author considers it to be due either to hypertrophy of the thyroid gland or to the development of adenoma. The disease had rarely commenced after the age of forty, most frequently in childhood; in comparatively few cases the development of the goître could be traced back to puberty or gravidity. In no less than 74 of the 117 families several individuals suffered from goître, and in 48 of these the disease appeared in the direct ascending or descending line, while it appeared only in the lateral branches in but 26 cases. Hemicrania, and this only in its typical form, where it has all the signs of a neurosis, was a symptom very frequently met with—both in the patients with goître and—and this was more frequently the case—in their relations with no goître, and also here the direct ascending or descending lines exhibited this nervous symptom most frequently. To show how hemicrania and goître occur alternately in a family, the author quotes a case, where the grandmother had hemicrania but no goître, the mother has goître without attacks of hemicrania, while of her two daughters, who both suffer from goître, the one also suffers from hemicrania, while the other one is free. Altogether the author quotes seven most interesting genealogical tables, showing the heredity of goître, especially in the direct line, and its close relationship to hemicrania, which the author does not consider as resulting from a mechanical pressure of the thyroid gland, but as a co-ordinate symptom of disease of the vaso-motor system, three patients out of the 117 families suffered from Basedow or Graves' disease. A very large number of the patients observed suffered from anæmia, as also was found in several cases a marked hæmorrhagic tendency, and this occurred more frequently in individuals with no goître; in one family four females had goître and five suffered from menorrhagias, which in one case resulted in death under the author's treatment. There were found thirteen cases of mental disease and four cases of deaf-mutism.

The author considers goître as being of vaso-motor origin, as put forth by Woakes, and sees a corroboration of this theory in the fact, that in the families with goître observed by him, other diseases, which can also be explained as vaso-motor diseases, occurred so frequently.

The essay, which seems to be founded on very thorough and careful observations, deserves attention as a valuable contribution to the etiology of goître. **Holger Mygind.**

TSARYROGBOAS (Smyrna).—**Some Notes on Goitre in Asia Minor.** *Monatsschr. für Ohrenheilk., &c.*, 1887, *No.* 12.

GOÎTRES are very frequent in Asia Minor. The inhabitants believe them to be caused by bad water. **Michael.**

HARRIS, ARTHUR (London) **and F.R.C.S.—Strumous Ulcers.** *Lancet, November* 26, 1887.

In reply to a querist, the former gentleman recommends the following treatment in strumous ulcers of the neck:—Bathe daily with warm water; dress with linen, &c., soaked in sweet oil; administer thrice weekly, at bed-time, from one to two grs. of calomel, and every morning mag. sulph., 3j; mag. carb., gr. x; pot. nit., gr. v in peppermint water. Continue treatment for three months or longer, omitting the calomel one week in four.

The latter recommends cleansing or scraping; dusting daily with iodide of lead; if sluggish, the application of chloride of zinc, one drachm to the ounce of water; also, cod-liver oil, hypophosphites, &c.

Hunter Mackenzie.

WALTERS, J. (Reigate).—**Discoloration of the Skin by Nitrate of Silver.** *British Medical Journal, December* 3, 1887.

Case of a woman, aged sixty to seventy, the subject of argyriasis, and who, many years previously, had been supplied with a solution of nitrate of silver to apply to her throat. **Hunter Mackenzie.**

DIXON, JOSEPH (Kempston, Beds).—**Salivary Calculus occupying Wharton's Duct, and a portion of the Sub-lingual Gland beneath.** *Lancet, November* 26, 1887.

Removed by operation. **Hunter Mackenzie.**

BRESGEN (Frankfort-on-Main).—**On Nervous Cough.** *Berlin. Klin. Wochenschr.*, 1887, *No.* 49.

He agrees with Rosenbach (see the report), and adds that such nervous coughs often arise from the effect of cold. **Michael.**

BUDD, RICHARD (Barnstaple).—**Is Cancer Contagious?** *Lancet, November* 26, 1887.

A letter to the Editor, in which is narrated the case of a gentleman who had cancer of the lip, which was frequently licked by a favourite little terrier. This dog died, before his master, of cancer of the tongue.

Hunter Mackenzie.

STRANGE, WILLIAM (Worcester).—**Gangrenous Abscess of the Lung, probably caused by the Stump of a Tooth passing into the right Bronchus, treated by Puncture and Drainage; Recovery.** *British Medical Journal, November* 26, 1887.

The nature of this case is indicated by the title. **Hunter Mackenzie.**

ASSOCIATION AND CONGRESS MEETINGS.

Ninth International Medical Congress.

SECTION IN LARYNGOLOGY.

Some Remarks on the History of Rhinology. By Dr. D. N. RANKIN (Allegheny, Pa.).

UNTIL a comparatively recent date, the nasal cavities have been sadly neglected. This neglect is more surprising in face of the facts that the nares furnish the natural medium for respiration; that they are the organ of smell, thereby protecting the lungs from the inhalation of deleterious gases, and assisting the organs of taste in discriminating the properties of food; and as an adjunct to the vocal apparatus in making a pleasant voice, they are indispensable.

It is certainly very desirable to have an acute sense of smell, though it is not so important as some of the other senses. Of its pleasures let me here mention a few. Every hill and vale and shore is tributary to the sense of smell. There appears to be a scale in odours with respect to the pleasures which they excite in the organ of smell.

"The rose appears to be at the head of this scale, the shrub next; the pink, the jessamine, the tuberose, the honeysuckle, the sweetbriar, all gradually descend from it. The pleasure derived from odours is much increased by mixture. There can be little doubt that these odours are so related to each other as to produce from different mixtures greater or less degrees of harmony, analogous to the vibrations of musical sounds. There is certainly something like bass in the smell of the magnolia and the lilac; the rose and the pink answer to tenor; and the jonquil and the mignonette are striking analogies of the softness and delicacy of treble tones."

The odour of flowers, certain vegetables, and meats in the process of cooking, is not only pleasant, but nutritious and medicinal, from the stimulus it imparts to the whole system through the medium of the sense of smelling. Country air owes one of its beneficial effects on invalids to this cause.

The sense of smell is liable to be perverted, as we see in the artificial pleasure which some people derive from the fœtor of the civet, musk, assafœtida, and even of the snuff of a candle.

Who, that never saw or experienced it, would believe that the odour of the rose could produce fainting, or that the heliotrope and the tuberose have made some persons asthmatical? The smell of musk, so grateful to many people, sickens some. It is well known that the sense of smell guides many of the lower animals to their food, or warns them of danger, as is exemplified in the hunting dog. The distance at which a dog tracks his master is scarcely credible. The acuteness of the sense of smelling in animals is such, that in many instances our observations have been deemed fabulous. Birds of prey will scent the battle-field

at prodigious distances, and they are often seen hovering instinctively over the ground where the conflict is to supply their festival. Ancient historians assert that vultures have cleft the air one hundred and fifty leagues to arrive in time to feast upon a battle-field. "Whence comes it that the redwing, that passes the summer in Norway, or the wild duck, that summers in the woods and lakes of Lapland, is able to track the pathless void of the atmosphere with the utmost nicety, and arrive on our own southern coasts uniformly in the beginning of October?"

It has been observed that animals which possess the most acute smell have the nasal organs most extensively developed. The American Indians are remarkable for the acuteness of this sense, which accounts for their wonderful power of tracking their enemies.

By a glance over the text-books you will find, in the chapter on nasal diseases, that they do not receive that attention they deserve. It is an undeniable fact, that perhaps no department of medicine has been so much invaded by quacks. It is true, they often acquire reputation and wealth, but this must be ascribed to the credulity of their patients, and to the zeal with which they exaggerate and advertise their cures, or palliate or deny their mistakes. It has been said, and well said, that quacks are the greatest liars in the world, except their patients. Quacks and impostors, said Lord Bacon, have always held a competition with physicians. Galen observed that patients placed more confidence in the oracles of Æsculapius, and their own idle dreams, than in the prescriptions of doctors. No science has been cultivated with more difficulty than that of this specialty. Sir Astley Cooper used to complain that a knowledge of the nasal cavities is by no means general in the profession, and still less are their diseases understood.

Compare the *armamentarium* of thirty years ago with the outfit of the nasal specialist of to-day. What was it previous to thirty years ago? Literally nothing! No perfect rhinoscope, no insufflators, no inhalers, no galvano-cautery, no incandescent light, no sponge-holders, no guillotine, no écraseur, no snares. A single pair of polypus-forceps and a cumbersome nose-speculum constituted the set. Whilst visiting the mountainous districts of Western Pennsylvania some years ago, I went into the office of the village doctor to pay my respects. He was a man of, perhaps, seventy years of age. In conversation I inquired if he had much nose and throat disease to treat. He said he "had considerable of that class of disease to look after." He then exhibited his nose and throat instruments, which consisted of a tongue-depressor and polypus-forceps. He informed me that the tongue-depressor was made by the village blacksmith!

Our forefathers depended principally upon general treatment and snuffs as, then, treatment locally was not thought of. If a person was unfortunate enough to have any of the many forms of disease of the nasal cavities, it was allowed to progress uninterruptedly, short of a constitutional treatment. It appears, from historical accounts, that the ancients, especially the Egyptians, made rhinoscopic examinations, but with what success is not stated.

Since Prof. Czermak, of Pesth, conceived the idea of, and introduced to the attention of the profession, the rhinoscope, wonderful indeed has been its utility in diagnosing affections of the nares, which previously had been very unsatisfactory and obscure. The usefulness of the rhinoscope, however, would have been greatly lessened had it not been for the ingenuity of other eminent rhinologists, who have devised many useful surgical instruments, as well as means for making therapeutical and electrical applications to the nasal cavities, as Jarvis's écraseur and snares, the steam atomizer of Siegle, the nasal douche of Thudichum, the insufflator of Robinson, the electrodes of Michael and Shurly, and many other valuable instruments which might be mentioned if time and space permitted, whereby local applications can as readily be made to the posterior nares as to the pharynx. Czermak has done for the nasal organs what the illustrious Laennec has done for the organs of respiration.

The therapeutics of the nares have kept pace with the surgical and electrical advances. Among the many excellent remedies that have been locally utilized, I would merely mention four—iodoform, chromic acid, cocaine, and bismuth. The general practitioner, when summoned to see a case of nasal disease, is too often satisfied with a too superficial examination. Generally, he raises the point of the nose somewhat, and then the vague pronunciations are uttered—"High up in the nares," or, "Deep down in the nares;" or, in the case of a child—"Let it alone; it will grow out of it." Therefore, it cannot be wondered at that the diagnosis and treatment of nasal diseases have been in a mixed condition.

We live in a revolutionary age. Our science has caught the spirit of the times, and more improvements have been made in this specialty within the past twenty-five years than in a century before. From these events, so auspicious to our department, we may cherish a hope that advancement may draw nearer perfection. Great Britain is entitled to a large share of the influence in the advancement of this specialty. It has contributed much to this movement by careful clinical observations of diseases of the nose, and by numerous contributions to our anatomical and physiological knowledge of nasal diseases. The German spirit, recognizing the importance of this new era, joined in, hand in hand. Austria, Denmark, Russia, France, Italy, and Spain are all well represented by men eminent in this specialty.

America, never behind in anything that conduces to the benefit of mankind, is represented by men of marked ability, as writers and teachers, as well as successful practitioners, in this specialty.

The American Laryngological Association—an institution we feel proud of, with a fellowship of over fifty members—is composed of the very best talent in this country, men who have already made their mark, and are all actively engaged in prosecuting their valuable labours.

It was my good fortune, during the last meeting of the International Medical Congress at Copenhagen, Denmark, to meet most of the members of the Laryngological Section, and, without a single exception, those I met were persons of the highest medical attainments, and gentlemen in every sense of the word. Here permit me to say a word in memory of

the father of rhinology and laryngology in America. I refer to the late Louis Elsberg, a man whose memory we should all revere, as not only a gentleman and scholar, but most eminent in rhinology and laryngology. He unquestionably did much to advance these specialties, and was among the first to successfully use the laryngoscope in this country.

To America is due the credit of bringing rhinology to its present status. Dr. Daly has. doubtless, done more to accomplish this end than any man in this country.

The ample means we now possess of investigating diseases of the nares, and the facility with which the true nature of these diseases is arrived at, are certainly very encouraging.

Comparing rhinology to a house, the different storeys of which have been erected by different architects, Czermak, Elsberg, and others have a large claim to our gratitude, for having, by their arduous and successful labours, advanced the building to its present height. It belongs to the rhinologists of the present and future generations to place a roof upon it, and thereby complete the fabric of rhinology.

D. N. Rankin.

The Present Status of the Galvano-Cautery in the Treatment of the Upper Air-Passages. Illustrated by Improved Forms of Electrodes and a Description of Cases. By Dr. F. B. EATON (Portland, Oregon).

THE prevailing treatment of nasal catarrh is now surgical. There is, however, no unanimity of opinion as to what is the best general plan for clearing the upper air-passages of obstructing hypertrophies, *i.e.*, by snare, cautery, acids, revolving knives and drills, or saws.

All these methods are, to an extent, overdone and abused, and withdraw attention from hygiene and constitutional treatment.

The principal aim of the paper is to claim for the galvano-cautery that, in the form presented, *it is one of the best and most available surgical instruments for the removal of nasal and post-nasal obstructions now at the disposal of the majority of surgeons.*

It cannot replace other methods which are more radical for the removal of certain obstructions.

It is, however, safer than acids, and is better adapted for use by the operator of average skill, for the instruments here shown are perfectly under the control of the operator, and can be handled with delicacy, and the temperature of the platinum readily graded. It is less intimidating to the patient than saws, snares, etc.

There is no pain when cocaine 10 % is used ; and hæmorrhage, beyond slight oozing, is rare,—cautery operations are essentially *clean* ones.

While *all* forms of hypertrophic tissue can be destroyed by the cautery save *large* exostoses, in some instances even deep cauterizations of *large* enchondroses only cause them to enlarge and take on the peculiar cystic or fatty degeneration to which they are liable.

The large pendant pharyngeal tonsil is best removed by Loewenberg's forceps or the finger-nail, the sessile ones by an "S" burner. In young patients suffering from persistently erected anterior inferior hypertrophies of the turbinated bodies, puncturing them with a long pointed

electrode, which is moved round under the mucous membrane, is preferable to surface cauterization, as the mucous follicles are preserved.

All the burners are complete in themselves, having their own handle, the circuit being closed with the foot; the battery used being that of Dr. Seiler, of Philadelphia (made by Otto Flemming, of Philadelphia, who also makes my burners). The most generally useful are the "scythe" and "lateral" burners (see *Transactions of the Ninth International Medical Congress* and *New York Medical Record* of August 28, 1886, for illustrations). The "scythe" burner is used from the front to destroy posterior hypertrophies.

Sufficiently exact records were kept of the last forty consecutive cases, and results are given in detail.

An original operative feature has been the destruction of the thinner crested exostoses at the base of the septum by burning through them with a "spatula" burner. **F. B. Eaton.**

Rheumatic Laryngitis. By Dr. E. FLETCHER INGALS (Chicago).

THIS is a painful affection of the vocal organ, attended by hoarseness and fatigue after talking, sometimes by grave obstruction of the glottis.

The acute disease, associated with articular rheumatism, has been recognized, but has been little studied.

Desbrousses, 1861, relates a case which was fatal. The patient, a woman, aged 24, suffered from acute articular rheumatism and pericarditis.

Brief references to the affection have been made by Besmer, Chomel, Lieberman, Dechams, and Prof. Jaccoud, and cases have been recorded by Fauvel, Coupard, and Joal. R. Archambault (*Thesis*, Paris, 1886), gives a history of the literature, and a *résumé* of five cases, one under his own observation. He concludes that "they are more common than supposed; they may affect separately various parts of the larynx—the muscles, membranes, articulations, or nerves of the larynx; congestions are the most easily determined of the lesions; suffocation may occur. In the treatment he recommends care to prevent the frequent occurrence of the congestion in predisposed persons. Susceptibility of the larynx to be combated by local fomentations and general bathing. At the beginning rest, diaphoretics, gargles, and inhalations are advised. In severe cases hot fomentations, and Tr. iodine, and sometimes vesication and leeches. In severe pain cocaine applied with a sponge-carrier will give relief. Salicylate of soda is beneficial at times. When suffocation is imminent tracheotomy must be performed."

No mention is found in literature of the chronic form.

Dr. Ingals says:—For some years I have observed chronic, painful affections of the larynx, attended by no erosions or ulceration and by little congestion or swelling. They usually occur in persons of rheumatic diathesis, but often the larynx or tissues about the hyoid bone present the only evidences of the constitutional disease.

Dr. Chapman, New Haven, Connecticut, recently described neuralgia of the pharynx and larynx, which at first seemed similar to those to

which I refer. However, they are quite different from those I term rheumatic.

This affection occurs usually in those of rheumatic diathesis, but often the only evidence of the constitutional disease is found in the larynx, or the tissues about the os hyoides. The pain is not constant, disappearing in fine weather especially, it may be, to return on slight exposure or on changes of temperature. Its course is erratic, but often obstinate. There is often a predisposition to rheumatism, inherited or acquired.

Several of my cases complained of hoarseness or aphonia. Pain in no case has been severe, in some cases being most noticeable when using the voice. It is often more troublesome when swallowing, and in attempts at deglutition. Pain is commonly referred to one side of the larynx, to the trachea, the region near the greater cornu of the hyoid bone, the base of the tongue, or the lower part of the tonsil.

One or both arytenoids may be slightly congested, or redness may be on one side of the fauces or pharynx only, the cords remaining clear. In some cases there is slight swelling, in others none.

The diagnosis is based on the history and symptoms. Acute catarrhal inflammation, chronic syphilitic laryngitis, and abnormal growths may be easily excluded. In tubercular laryngitis the history is different, and the parts are usually paler than in health, while in the rheumatic affection there is slight congestion, and the constitutional symptoms are less marked. In malignant affections pain does not often precede pronounced organic changes. For differentiating from neuralgia or paræsthesia the history must be carefully considered, and pains must be looked for in other parts. In the rheumatic affection there is usually slight redness, in neuralgia none. We must often await the results of treatment to decide.

Rheumatic laryngitis usually runs a chronic course, extending over varying periods, from two months to one or two years. There is sometimes immunity, at other times severe exacerbations of pain. Recovery may be expected. In treatment I have found benefit from local application of astringent and stimulant sprays. Sometimes the galvano-cautery has been of service. Internal remedies have been most relied on. Potassium iodide, salicylate of sodium, guaiac, colchicum, cimicifuga, extract of phytolacca, and oil of gaultherium have been used. The author presents the histories of five cases in illustration :—

Case I.—Mrs. W., aged thirty-two, complained of an almost constant pain in the larynx, which had continued four years, but was variable. The throat and larynx were congested. The pharynx was so very sensitive, she could not tolerate inspection. She declined local treatment. The patient gave a hereditary history of rheumatism, and had suffered from rheumatic pains. She was not subject to neuralgia. Anti-rheumatic remedies were ordered. They were taken a short time, but were not persisted in. The soreness continued at intervals for about two years, when the symptoms gradually disappeared.

Case II.—H. G., aged forty-seven. General health good. For two months he had pain and a sense of fulness in the larynx. The soreness was not constant, appearing suddenly, and lasting three or four days. The pain was referred to the upper part of the left side of the thyroid cartilage. The voice was occasionally husky or aphonic during the attacks. He had frequent attacks of muscular rheu-

matism. There was congestion of the epiglottis and left wall of the larynx, a slight swelling of the latter, and slight congestion of the vocal cord. The patient took twenty-grain doses of potassium bromide four times a day, and fifteen-minim doses of oil of gaultherium. A sixty-grain solution of argentum nitrate was applied to the left side of the larynx. In eight days he was nearly well, but the soreness appeared lower down. The pain shifted to the larynx again in a few days, then to a point beneath the sternum. In sixteen days he returned home, free from pain. The pain returned subsequently from time to time.

Case III.—Miss I. G., aged twenty-two. General health good. The voice had been weak for four years whenever she attempted to shout. For a month there had been aching in the laryngeal region after using the voice for a short time. The soreness was worse in damp weather. There was paresis of right cord, no swelling nor redness. She complained of pains in other parts of the body, which seemed rheumatic. Under salicylate of soda, acetate of potassium, and oil of gaultherium she improved rapidly.

Case IV.—J. C. R., aged thirty-nine. Patient complained of pain in the shoulders, chest, and back of head, and of aphonia of four months' duration. He gave a history of inflammatory rheumatism, and of frequent slight sore throat. Bi-lateral paralysis was present of the lateral crico-arytenoid muscles. No congestion nor swelling could be seen. The paralysis and its results were undoubtedly due to rheumatism.

Case V.—C. F. M., aged twenty-nine. General health perfect. He had had soreness of the throat for four months, occasional hoarseness, rheumatic pains in the back and chest, and in the regions of the trachea and hyoid bone. The pain was aggravated by damp weather. Stimulant applications were made to the throat, and anti-rheumatics were used internally. Improvement was speedy.

The attacks were renewed every four to six weeks subsequently for some time.

Besides these cases noted, several others have been under my treatment. I am confident that, with more critical observation, we shall find many similar cases, due to the same causes as muscular or articular rheumatism.

E. Fletcher Ingals.

Resorcin in Nasal Catarrh.—By Dr. THRASHER (Cincinnati).

THE remedy is applied for the first week daily to the cleansed mucous membrane. After the first week the nasal atomizer is used every second or third day, and on the other days the patient uses an ointment (two to four per cent. of resorcin in vaseline), applying it to the nasal mucous membrane by means of a small camel hair brush. My notes on forty cases treated in this way show that ten were dismissed cured in three weeks, fifteen in four weeks, seven in five weeks, four in six weeks, and three in two months. One obstinate case, where exacerbations were frequent, and which would tolerate only the weakest solution of the drug, seemed to not be entirely well at the end of twelve weeks' treatment.

These cases were all essentially chronic, having had symptoms of stenosis and an excessive muco-purulent discharge for from one to ten years Some of these patients since their discharge have returned with attacks of acute coryza, which, however, has readily yielded to the usual treatmen. given such cases. In summing up my experience with resorcin in the treatment of nasal catarrh, I would say :—

1. It is most useful in chronic nasal catarrh accompanied by œdema of the mucous membrane without much hypertrophy.

2. These cases are, as a rule, cured in from three to six weeks.

3. Resorcin should be used daily in from two per cent. to five per cent. solution in vaseline or olive oil, as a spray, or in the form of an ointment.

4. Resorcin allays the œdema of the turbinated bodies, checks the over-secretion of the mucous glands, and leaves the membrane in a normal condition.

5. In acute coryza resorcin is not necessary ; in atrophic and in hypertrophic rhinitis it is not useful.

6. Its good effects are due to its power of lessening the calibre of the hyperæmic vessels, of reducing the œdematous and semi-hypertrophic mucous membrane, and of hardening (tanning) the epithelial cells ; and to its remarkable antimycotic properties.

On Hay Asthma. By Dr. I. P. KLINGENSMITH (Blairsville, Pa.).

AT no time in the world's history, since the day Dr. John Bostock, in 1819, presented the first formal paper on this subject to the London Medico-Chirurgical Society, have more eager scientific workers been in the field in the pursuit of knowledge and its practical application to disease, than at the present. In no subject can you find a better proof of this fact, than in the disease now under consideration. I will not occupy your valuable time by giving a detailed history of the symptoms, course, and duration of the disease, but will confine myself to submitting for your consideration the results of my investigations so far as they bear broadly and directly upon the method of treatment I propose to advocate. In very few diseases do we find such a diversity of opinion in regard to the cause as in hay fever. Bostock attributed it to heat, while his contemporaries differed on this point. Since that period many theories have been advanced, but considerable diversity of opinion exists even at the present time. Until within the last five or six years, inquiry has been directed to the investigation of the exciting causes of the attack, and the predisposing or more important cause of the disease has been overlooked. Most of the literature upon the subject of hay fever, hay asthma, autumnal catarrh, or by whatever name it may be designated, is devoted to the extraneous or exciting causes of the malady in question, and numerous remedies, which serve simply to divert the mind of the sufferer, without resulting in any practical benefit, are suggested. Each patient coming under our observation should be subjected to a thorough rhinoscopic examination, allowing all fine-spun theories and extrinsic causes to take care of themselves. To Dr. W. H. Daly, of Pittsburg, Pa., belongs the honour of first calling the attention of the profession to the important part which diseases of the naso-pharyngeal cavities play in the production of hay fever. He, in a paper read before the American Laryngological Association in 1881, showed that the exciting causes of the disease are innocuous in those cases in which disease of the naso-pharyngeal cavities does not exist ; and proved further, from clinical evidence, that the disease is a curable one, by removing the intrinsic local cause and restoring the parts to a normal condition.

The succeeding year, Dr. John O. Roe, of Rochester, N.Y., read a

paper before the Medical Society of the State of New York, practically corroborating the investigations of Dr. Daly.

In 1883, Dr. Hack, of Freiburg, Germany, a special labourer in this field, made known the result of his investigations ; also holding the view that pathological conditions of the nasal mucous membrane play the most important part in the production of the disease.

The investigations of other observers substantially affirm the same theory. In reference to my own personal experience, I will simply say that of the thirteen cases that have come under my personal observation, in each one of them has disease of the nose or naso-pharynx existed.

The numerous exciting or extrinsic causes which have been supposed to bring on attacks of hay fever would occupy several pages, and I will therefore simply refer to a few of the more prominent. In those cases where local irritability or any deviation from the normal condition of the nasal cavities exists, an attack may be brought on by almost any exciting agent—an odour or vapour, dust, light or heat, the pollen of flowers or grasses.

In some cases I have known the attack to date from a severe cold. In support of the view that almost any agent may produce a paroxysm, I will mention the case of a patient who is so susceptible to the influence of Ipecac. and Dover's powder as to be able to produce an attack at any time by their inhalation. More recently the case of a young man, a miller by profession, has come under my observation, in whom the paroxysms are produced by the inhalation of small particles of flour while following his occupation.

During the past few years great advances have been made in bringing the treatment of hay fever within the radius of a more scientific standpoint, based upon a nearer approach to a rational pathology of the disease. Based upon my own investigations, as already stated, I am compelled to adopt the view that in each case of hay fever does a condition of the nasal or naso-pharyngeal cavities exist varying from the normal. When we view these facts and theories, with a view of carrying out a rational plan of treatment we should in every case make a thorough anterior and posterior rhinoscopic examination.

In a great majority of cases a chronic nasal catarrh exists, with sensitive areas not confined to any *particular* portion of the mucous membrane. In other cases I find a true hypertrophic condition, either anterior or posterior, or both. Polypi or deflections of the nasal septum may also act as a prominent factor in the propagation of the disease.

Fully believing that hay fever is due to local irritatives brought in contact with a diseased condition of the nasal mucous membrane, I am therefore compelled to call attention to the local or radical treatment as the chief mode of relieving or curing the disease. This plan, in the hands of Daly, Roe, and others, besides myself, has been followed by the most lasting and signal success.

When nasal polypi exist I remove them by means of Allen's nasal polypus forceps, or Jarvis's snare, always making sure to thoroughly cauterize the base with the galvano-cautery or glacial acetic acid. If large hypertrophies, either anterior or posterior, are found, they should be

removed by means of the Jarvis snare. Smaller hypertrophies and sensitive areas I destroy by using the galvano-cautery, chromic acid, or glacial acetic acid, giving preference in the order named. All surgeons have favourite instruments and appliances, giving preference to some, while discarding others.

The battery in use by me now for several years was devised by Dr. Seiler, of Philadelphia, and fulfils every indication required by the operator. The current can be controlled by the foot of the operator, thus giving him the use of both hands, and the temperature of the knife can be regulated to any degree of intensity. In using the galvano-cautery, I introduce an Allen's hard rubber nasal speculum, through which the electrode is placed on the spot to be cauterized, after which it is brought to a cherry-red heat. Great care must be taken to have the electrode at the proper temperature when applied to the tissue about to be destroyed, as, when too hot, free hæmorrhage may result, and when too cold, great pain will be produced. As a certain amount of inflammation is necessarily produced, not too large an incision should be made at any one sitting. My preference is given to the galvano-cautery, since it can be brought more fully under the control of the operator than chromic acid, and is less painful than glacial acetic acid. The pain produced, as a rule, is but momentary, except occasionally in persons of a highly nervous organization, when I apply a 4 per cent. solution of hydrochlorate of cocaine, either by means of the atomizer or an aluminium probe enveloped in cotton. The operation should be repeated about once a week, or as often as admissible, being governed by the degree of inflammation produced, until all hypertrophies and sensitive spots are destroyed. During the intervals of the operations the patient is directed to use as an insufflation Dobell's or some other alkaline solution.

In the application of chromic or acetic acid, I use the Bosworth's applicator. The treatment should be commenced about two months before the accession of the attack, and the nasal cavities should be restored to as nearly a normal condition as possible, relieving them of all hypertrophic conditions and sensitive areas. While I am of the opinion that treatment should be commenced several weeks prior to the expected attack, yet in no case do I desist from operating even when the disease is at its height. In several such cases have I known the intensity and duration of the paroxysms to be shortened.

Of the thirteen cases upon which my observations are based, nine have been practically cured, and four, in whom the treatment could not be carried out perfectly, were greatly benefited.

In conclusion, permit me to say that I have tried to outline, in as brief a manner as possible, the essential points of this method of treatment, but, as will be observed, much pertaining to the minor details has been necessarily omitted, which is essential to a proper understanding of the subject.

I. P. Klingensmith.

REPORTS OF SOCIETIES.

Sheffield Medico-Chirurgical Society.

October 27, 1887.

Mr. PRIESTLEY (Sheffield).—*Demonstration of Specimen of Aneurism of the Arch of the Aorta, in a Drunkard, which had burst into the Trachea.*

November 10, 1887.

GARRARD, —.—*Rupture of Trachea; General Emphysema; Death.*

A GIRL, aged eight, fell on a sharp-edged slate hanging round her neck, bruising the front of the neck. Swelling from emphysema commenced at once, and when brought to the hospital, about an hour after the accident, it had extended to every part of the body, even to the fingers and toes. She died a few minutes after admission. No post-mortem was allowed, but a distinct depression could be felt just below the cricoid cartilage. Mr. Garrard much regretted that so much delay occurred in bringing the child to the hospital, and thought that, had an early incision been made over the trachea to the injured part, life would have been saved.

South East Hants Medical Society.

November 2, 1887.

J. WARD COUSINS (Portsmouth).—*Disease of the Cervical Vertebræ.*

EXHIBITION of a boy aged eleven years. The disease appeared to have been completely arrested, under treatment by rest and sand bags, although a good deal of thickening still remained at the back of the neck.

Harveian Society of London.

November 3, 1887.

J. HUTCHINSON, Jun. (London).—*The Teeth in Inherited Syphilis.*

THE fallacy of looking for characteristic signs in the temporary teeth was dwelt upon, their liability to premature necrosis and falling out being illustrated by specimens. The teeth which in after life showed syphilitic deformity in the greatest degree were those which calcified first, namely, the permanent incisors and first molars. The upper central incisors were the real test teeth of inherited syphilis, though many children who inherited disease presented perfectly normal teeth.

Dr. HUGHLINGS JACKSON remarked upon the importance of a wide and exact knowledge of the particulars and decisive signs of inherited syphilis.

Brighton and Sussex Medico-Chirurgical Society.

November 3, 1887.

MACKEY, —.—*Unusual Organs from a Child.*

THE child was five years and a half old. Amongst the organs exhibited was the larynx, the ary-epiglottic folds of which were sloughing, with the presence of shreds of membrane. The clinical history of the last illness suggested diphtheria commencing in the bronchi and extending upwards. (This mode of origin and extension of diphtheria is somewhat unusual.)

Leeds and West Riding Medico-Chirurgical Society.

November 4, 1887.

Dr. MYRTLE (Harrogate).—*The Difficulties in Diagnosis of Early Condition of Malignant Disease.*

A PATIENT was shown who twelve months ago complained of a peculiar sensation at the lower end of the sternum on swallowing, and of shooting pains about the anterior chest wall, having special difficulty with certain acid fluids. For a time relief was obtained by the administration of cocaine, which on one occasion caused symptoms of intoxication, but the dysphagia came on again, accompanied by hæmorrhage. He was seen at various times by eminent consultants (including a throat specialist), and the diagnosis included spasm, neuralgia, localized simple inflammation, and aneurism of the aorta. It was only at a later date that a growth occluding the œsophagus, and a mass occupying the cardiac end of the stomach, were demonstrated. After complete obstruction of the gullet the patient lived for twenty-six days while fed by the rectum only.

Dr. CLIFFORD ALLBUTT thought the general cachexia was an important point in the diagnosis of malignant disease from neuroses or inflammation.

Dr. BRAITHWAITE thought cancer was always accompanied by quickness of the pulse.

Mr. LAWFORD KNAGGS asked whether a certain amount of relief could not have been obtained by gastrostomy.

Dr. JACOB remarked on the use of the bougie in diagnosis, and the utility of intubation where the stricture was not too low.

Dr. EDISON said his experience of surgical treatment of malignant stricture of the œsophagus was very unsatisfactory.

Mr. MCGILL said his first gastrostomy was his only successful case, the patient living for six months. He intended in future to open the œsophagus in suitable cases.

November 18, 1887.

A. H. JACOB (Leeds).—*Case of Syphilitic Laryngitis.*

EXHIBITION of a man who had had a chancre ten years previously. The epiglottis was partly destroyed, and there was much thickening of the vocal cords.

ROBSON, — (Leeds).—*Acute Glossitis.*

EXHIBITION of a young woman, the subject of this complaint. Four years previously, the tongue, which was the subject of macroglossia, became acutely inflamed, and he removed a wedge-shaped piece. Three weeks ago she had another attack, with no apparent cause. The piece formerly removed showed an overgrowth of adenoid tissue, but no trace of lymphangiectasis.

West London Medico-Chirurgical Society.

November 4, 1887.

PERCY DUNN (London).—*Epithelial Growth of Tongue.*—Card case.

HERRINGHAM, — (London).—*Case of Syphilitic Laryngitis.*—Card case.

SPICER, — (London).—*Obstruction of the Nose: its Bearing on Throat and Ear Disease, and its Treatment.*—Paper read.

THIS paper contains nothing new, and the discussion which followed has not been reported.

Medical Society of London.

November 7, 1887.

A. MARMADUKE SHIELD (London).—*Acute Glossitis accompanied by Trismus.*

CHILD, aged six years, with swelling of the tongue and spasmodic contraction of the jaws suddenly supervening upon recovery from quinsy. At the end of a week the tongue was enormously swollen and protruded from the mouth, the teeth being buried in it. Swallowing was impossible, and breathing was seriously impeded. Under chloroform, the tongue was freely incised, with profuse bleeding. It at once diminished in size, and the spasm of the jaws gradually relaxed, but paralysis of the tongue persisted for several days. The attack was attributed to direct extension of inflammation from the pharynx.

Dr. SIDNEY PHILLIPS, who had known several cases from bad drains, asked whether the child had been exposed to any other cause of septic poisoning than wounds.

Dr. ANGEL MONEY called attention to the very singular liability to spasm of the particular portion of the fifth nerve.

Mr. SHIELD, in reply, concurred in Dr. Phillips' suggestion, which was very probable.

British Medical Association: Birmingham and Midland Counties Branch.

November 10, 1887.

BENNETT, MAY (Birmingham)—*Cleft Palate.*

A YOUNG girl was shown who had been most successfully operated on. The exhibitor thought such cases were most likely to give perfect results which were not too young.

Northumberland and Durham Medical Society.

November 10, 1887.

LIMONT, — (Newcastle-on-Tyne).—*Adenoid Vegetations in Pharynx.*

EXHIBITION of a girl, the subject of this disease.

British Medical Association: Yorkshire Branch.

November 16, 1887.

ADOLPH BRONNER.—*Post-nasal Growths, and their Relation to Disease of the Middle Ear.*

PAPER read, but not reported.

Sunderland and North Durham Medical Society.

November 17, 1887,

MORGAN, — (Sunderland).—*Salivary Fistula.*

EXHIBITION of a patient who had been successfully operated on.

GRAY, —.—*Gastrostomy.*

EXHIBITION of a man who had been operated on two months previously for carcinoma (?) of the œsophagus. Since the operation the patient had increased twelve pounds in weight.

Medical Society of the Hospitals.

November 22, 1887.

Thyroid Leucocythæmia. HAYEM.

THE author related the case of a woman sixty-two years old, until lately in excellent health. After the birth of her last child, now fourteen years old, she

noticed a swelling of the right globe of the thyroid gland, but this swelling remained stationary until last October. From this time it has augmented considerably, has displaced the œsophagus and trachea, and given rise to trouble in deglutition and suffocative paroxysms. The carotid artery passes in front of the tumour, which is of hard consistency, and presents no bruit. The cachectic aspect of the patient suggested to the author an examination of the blood; he found a considerable augmentation of the white blood corpuscles (70,000 per cubic millimeter), nothing in the liver or spleen, and no trace of glandular enlargement. The author asked if this very rapid development of goître might not be the cause of the leucocytosis (which, considering the hæmatopoietic functions of the thyroid body, would not be extraordinary). And he asked further for suggestions as to treatment of the condition which menaced the life of the patient.

M. BUCQUOY suggested injections of iodine, commencing on the periphery of the goître, repeated frequently on isolated spots. If it were not a malignant tumour (and one might suspect sarcoma) this would probably cure the condition.

M. HAYEM said that he had thought of iodine injection, but bearing in mind that each injection caused an inflammatory swelling, he was afraid, in the patient's condition, of inducing asphyxia.

M. MOUTARDE-MARTIN suggested electrolysis in case the tumours were cystic.

M. HAYEM remarked that there was no fluctuation or souffle, but the tumour was of myomatous consistence.

M. RENDU remarked that in Alexander's thesis, leucocytosis was met with in the course of carcinoma. Might not the tumour be of this kind?

M. HAYEM replied that leucocytosis is not met with in all cancers, and, moreover, when it does exist, the number of white globules has never been more than 30,000, whereas in simple leucocytosis one may find as many as 200,000 white corpuscles in a cubic millimeter. The absence of pain also in this case contra-indicated a diagnosis of malignancy.

M. BUCQUOY remarked that this last sign was of no absolute value. He had recently seen, with MM. Tillaux and Terrillon, an extremely rapid sarcoma of the thyroid, which was entirely painless.

M. CHAUFFARD said that if M. Hayem believed in leucocythæmic nuclei in the thyroid body he might try selections of Fowler's solution in small doses.

M. HAYEM replied that this is what he proposed doing, since Fowler's solution was the only medicament which had any chance of success in leucocythæmia.

Joal.

British Medical Association: South Eastern Branch—East Kent District.

November 24, 1887.

WACHER, —.—*Unusual Complication of Typhoid.*

THIS consisted of an abscess which formed in the thyroid gland, and subsequently gave rise to fatal arterial hæmorrhage. The origin of such an abscess and the method of treating the fatal bleeding is stated to have been freely discussed, but is not reported.

Hunter Mackenzie.

Clinical Society of London.

November 25, 1887.

R. CLEMENT LUCAS (London).—*The Congenital Absence of an Upper Lateral Incisor Tooth as a Forerunner of Hare Lip and Cleft Palate.*

THE object of this paper was to show the danger of a deformity partially developed, and likely to pass unobserved. The author wished to point out that the

congenital absence of an upper lateral incisor tooth might foretell the probability of cleft palate in a succeeding generation. In support of this opinion three cases were narrated.

Mr. F. J. BENNET remarked that the teeth most commonly absent from the jaw were the lateral incisors. No importance was attached at the dental hospitals to the frequent absence of the lateral incisors.

Wiener Doctoren Collegium.

Meeting, December 19, 1887.

SCHNITZLER.—*Perichondritis Laryngea: Cure by Pot. Iod.*

THE patient, aged thirty, was hoarse for one year; had a cough and difficulty in swallowing. The laryngoscope showed swelling of the whole mucous membrane. Inunction of mercury was without effect. The condition was cured by iodide of potash. **Michael.**

Berlin Medical Society.

Meeting, January 4, 1888.

SENATOR.—*On Acute Infectious Phlegmon of the Pharynx.*

THE author referred to two cases in which swelling and suppuration of the pharynx with œdema of the glottis suddenly developed with high fever. Both patients died in a short time of septicæmia. The author had also seen such cases formerly. Their diagnosis is very easy; their prognosis is fatal. **Michael.**

REVIEWS.

WOAKES, EDWARD.—Nasal Polypus, with Neuralgia, Hay Fever, and Asthma, in relation to Ethmoiditis. *London: H. K. Lewis,* 1887, pp. 140.

WHEN Alice undertook her remarkable journey into "Wonderland," she scarcely saw more extraordinary things than Dr. Woakes's experiences in his flights into the realms of Rhinology! One is fairly staggered at the illimitable extent of our author's imagination. The largest superstructure, the grandest theory, is erected upon a base which, alas for our author's philosophy, is of the slenderest nature. "Hyperbole is heaped on hyperbole," and Dr. Woakes has in this brochure a nasal polypus even surpassing his former effort on post-nasal catarrh. To Dr. Woakes, "necrosing ethmoiditis" is the "hub" of the universe, at least of its rhinological section, and apparently the source of all the ills that flesh is heir to, at any rate of such as by any stretch of imagination can be referred to a wicked and evil disposed nasal organ.

Seriously, the theoretical meanderings and conclusions of our author are founded on two propositions:—

1. That all nasal polypus is necrosis of the ethmoid bone.

2. That a variety of distant reflex phenomena originate from this condition, by implication of the sympathetic nervous system.

Without attempting to criticize Dr. Woakes's conclusions in any detail, for which, even had we desire, we have not space at our command, we will merely remark that, before the first proposition can be accepted, much more certain pathological and clinical evidence must be brought forward than Dr. Woakes presents. All the world—rhinological, at any rate—is familiar with the fact that the passage of a probe through a mass of polypus will indicate to one that there is exposed an apparently "dead" (for want of a better term) bone underneath, but it has yet to be proved that this is in all, or even in any, cases "necrosis." All the characteristics of such a condition are absent, and to call all cases of polypus or hypertrophied turbinated bodies "necrosing ethmoiditis" is simply to apply a very pretentious term to a very common condition, without, notwithstanding the author's pathological diagrams, anything more than the slenderest evidence in favour of such an unusual condition. Dr. Woakes rather concedes the question, when he remarks (p. 22), "it does not follow that any causal relationship is postulated as existing between the presence of polypus and that of necrosing ethmoiditis." With regard to the author's second proposition, the consideration of which occupies the greater part of his work of 138 pages, we may remark that he and other offenders who treat us to reams of writing upon the disorders of the sympathetic system, *viâ* the nose, would do rhinology much more service if they would leave this realm of unprofitable speculation, and treat us to one undoubted experimental proof that these isolated ganglia (*e.g.*, Meckel's, the superior cervical, &c.) possess afferent and efferent nervous systems, and can become centres of reflex action. There is nothing to support such a contention beyond assumption and assertion, and the mischief of it is that those who write most profusely of the disturbances of the "sympathetic system" (that much-abused nervous chain) show the slenderest acquaintance with physiology. It is all wild theory. When we come to seek for physiological experimental proof of the independence of these isolated ganglia as subsidiary centres of reflex action, we not only do not find it, but all experience leads to the very opposite conclusion. Does not every physiologist remember the controversy waged over the sub-maxillary ganglion, and the physiological proof arrived at that it was in no sense a centre of reflex action? So far as experiment has dealt with the sphenopalatine, Meckel's and other ganglia, the same conclusions must be arrived at, and the brilliant researches of Gaskell have shown that the sympathetic system is not independent of the central nervous system, and its ganglia are not centres of reflex action. A great deal that is absolutely unphysiological is written on nervous pathology by rhinologists. It is conceived in the study under the influence of midnight oil, and not arrived at by the more laborious method of experimental investigation. As travesties on physiology, such books as our author's may be read with amusement, but the worst of it is that this production is only one example of many of a similar kind, and of much rhinological literature that is stale, flat, and unprofitable. We have dwelt upon this matter

at some length, with regard to Dr. Woakes's latest literary production on account of the writer's authority in matters of practice. If he will establish his conclusions experimentally, he will succeed in revolutionizing many things in rhinology until that is forthcoming, we are bound to state that Dr. Woakes's theories, and the practice founded thereon, will be dangerous guides to follow. For that reason the book should not be put into the hands of young rhinologists. It may, however, supply a little postprandial and physiological excitement to older practitioners.

SPICER SCANES.—Forms for Systematically Recording Observations and Results of Treatment in Affections of the Throat and Nose. *H. K. Lewis*, 1887.

THE want of some systematized plan of note-taking is felt by most rhinologists and laryngologists. Dr. Spicer has attempted to meet this in a praiseworthy manner, and though we think these "forms" might be improved upon, we can readily understand that they may be a great convenience to many clinical assistants. They err by endeavouring to be too comprehensive, and are consequently too bulky, and rather expensive (7s. 6d. per 100).

Die Bildung der Gesangsregister (The Formation of the Singing-Registers, by J. MICHAEL (Hamburg). *Hamburg and Leipzig: Leopold Voss*, 1887, *pp.* 76.

THE author has, in this little treatise, succeeded in presenting a subject in a manner which cannot fail to be interesting both to singers and teachers. The work is decidedly original, and the important and little-understood subject of the formation of the registers is handled with considerable skill, and in a scientific spirit. It is not our intention now to lay before our readers or to criticize in detail the author's views, since we understand that an English translation of this treatise is shortly to appear, which will receive attention. The author precedes the serious part of his work by expressing the view that the study of the functions of the larynx, and of the physiology of voice-production, is not in the least essential to the singer, and strongly deprecates the misuse and misapplication of physiology adopted by some modern singing-masters. This knowledge may, however, be put in the hands of a singer provided he regard it only as accessory to his art. To the physician, who hopes to cure a singer's troubles, a knowledge of the physiology of voice-production is, however, absolutely essential. We heartily concur in Dr. Michael's sensible remarks, and are sure that the less the singer knows of what, to him, can be only physiological jargon, the better his art will be. Dr. Michael recognizes four registers, in the production of each o which one muscle has predominant or controlling action. A few judicious remarks are inserted to warn the physician not to deal too energetically with certain pathological conditions in singers, and a very important part of the work is devoted to a study of the crico-thyroid muscle. We congratulate Dr. Michael on having produced an extremely interesting treatise, which should be read by all who have the care of the voice at heart, and we shall welcome the English translation of the author's work.

NEW PREPARATIONS.

PUMILIO PINE PRODUCTS. (G. & G. STERN.)

The Oil of Pine has for long been employed with great success in chronic and sub-acute catarrhal affections of the throat and lungs, and at various places on the Continent the "Pine Treatment" is most thoroughly carried out. Messrs. Stern have endeavoured to introduce this method into England, and, moreover, present to the public Pine Products of great purity. We have received some samples from them, which we have submitted to practical examination.

1. Pumiline Pine Essence.—In choosing an Oil of Pine for purposes of inhalation, it is most important that the oil to be employed should be free from irritating properties. The Pumilio Pine Essence of Messrs. Stern is prepared from Alpine trees, grown above the snow line entirely, such trees being known to yield not only a larger quantity, but a much purer quality, of Pine Oil than those grown at lower altitudes. The purity of Messrs. Stern's preparation is undoubted, and it contains, probably, fewer hydrocarbon oils than any other similar preparation in the market, which fact alone makes it the best Pine Oil obtainable for inhalation treatment.

2. Pumiline Pine Extract.—This is a thick, treacly substance, extracted from the young leaves and shoots, pleasant and agreeable, very soluble in water, and leaving no stain upon linen, &c. It may be used to make pine baths, poultices, or plasters, and is a most valuable external application, especially in rheumatic or gouty conditions.

3. Pumiline Jujubes.—Form an agreeable and efficacious application for sore throat (pharyngitis, tonsillitis, &c.).

4. Pumiline Soap.—Is a very useful preparation.

All pumiline preparations are powerful deodorizers and disinfectants, and besides their great value as tonic and stimulant applications to mucous membranes, they may be employed efficaciously to counteract the odour from foul secretions of the nose, throat, and lungs (such as caries, ozæna, gangrene, &c.).

We accord to Messrs. Stern's preparations the first place in the market.

PASTILLES OF IODOL. (J. L. BULLOCK & CO.)

These Pastilles, containing each one grain of Iodol, have been prepared according to the directions of Dr. Norris Wolfenden (See *Practitioner*, 1887), and must supplant the favourite but very nauseating pastilles of iodoform, in all cases where the antiseptic and therapeutic properties of iodoform are required, in treatment of pharyngeal and buccal disorders. They are of the greatest therapeutic value, and Messrs. Bullock's Pastilles are an elegant preparation.

ÆSCULAP MINERAL WATER. (INGRAM & ROYLE.)

The value of this Natural Mineral Water, as an aperient, has already been well established, and we need only remark that it has a well-deserved reputation. It is, perhaps, not as much employed as it ought to be, for it is one of the most effective and least nauseous of all the natural aperient waters.

NATURAL CARLSBAD SPRUDEL-SALT. (INGRAM & ROYLE.)

This has long been a favourite preparation in the treatment of hepatic and gastro-intestinal disorders, and we know of no more valuable aperient preparation to correct the irregularities of those who suffer from such complaints, as the result of leading sedentary and indoor lives.

VICHY WATER. (INGRAM & ROYLE.)

The Natural Waters of Vichy are well known, and are successfully employed in various rheumatic and gouty conditions. The various Vichy Waters form agreeable table waters for daily use, and their therapeutic value is undoubted. The addition of a glass of sherry, or a little whisky, renders them very palatable. The "Celestin" water is probably the favourite.

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés *d'envoyer un numéro de tout journal* contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Um die rechtzeitige Veröffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W., zu senden.

London: Pardon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Articles, p. 147.—The Action of Caustics on the Nasal Mucous Membrane, by Dr. FRANCKE H. BOSWORTH. On Intubation of the Larynx, by Dr. J. O'DWYER.

New Instruments and Therapeutics, p. 150.—PORCHER: A Self-Retaining Uvula and Palate Retractor. ROSER: A Fixable Laryngoscope. A New Apparatus. KITCHEN: The Intra-Nasal Plug. BRAUN: Application of Chromic Acid to the Larynx. BARBOT: Treatment of Whooping-Cough. SWETT: Quinine in Whooping-Cough. WITHERLE: Sulphide of Calcium in Phthisis. FILLEAU AND PETIT: Inhalation for Phthisis. ALVIN: Iodoform in Certain Anorexias; Solution of Chloride of Zinc.

Diphtheria, p. 152.—SCHRAKAMP: On Pathological Degenerations. WERNICKE: True or False Croup. TOMÉ COSPÉDAL: Diphtheria. SCHMEIDLER: Treatment of Diphtheria. SCHUCHARDT: Essay on Tracheotomy. SOTA Y LASTRA: Intubation of the Larynx in Croup: GREENWOOD: Case of Laryngeal Diphtheria.

Nose and Naso-Pharynx, p. 154.—HERZOG: Eczema of Orifice. VRUNNELA: Intermittent Dyspnœa. RUAULT: Nasal Reflex Neuropathies. BROWN: Paroxysmal Sneezing. COEN: Rare cases of Nasal Speech. SOURDRILLE: Reflex Neuroses. GARRIGOU-DESARENES: Chronic Catarrh. LEFLAIVE: Summer Asthma. BOND: Mucous Polypus in the Child. NOQUET: Foreign Bodies causing Fœtid Rhinitis. BOUCHER: Deviation of the Nasal Septum. VEREHERE: Operations in Recurrent Tumours. HOPMAN: Removal of Tumours from the Naso-Pharynx. CARTAZ: Phonetic Troubles after Ablation of Adenoid Vegetations.

Mouth, Tonsils, Pharynx, &c., p. 157.—PORTER: Communicability of Syphilis through the Saliva. LECKIE AND CARLTON: Ibid. PAGE: Ankylosis of Temporo-Maxillary Joint. DESCROIZELLES: Œdema of the Glottis. TRELAT: Epithelioma of the Tongue, etc. VERNET: Nigritis of the Tongue. LEUDET: Hemiatrophies of the Tongue. LE BEC: Epithelioma of the Tongue. GRIFFIN: Adhesion of Soft Palate to Pharynx. NATIER: Adenoma of the Palate. BLACHE: Hypertrophy of the Palatine Tonsils. PREUSS: Treatment of Polypi with Ergotine. MENDES and BONITO: Pharyngo-Mycosis. SOTA y LASTRA: Ludwig's Angina. BURKHARDT: Opening of Retro-Pharyngeal Abscesses. TESSIER: Stricture of the Œsophagus and Tuberculosis.

Larynx, p 161.—CASADESUS, ROGUER: Progress of Laryngology. BARON: Acute Œdematous Laryngitis. KOEBERLE: Polypous Tumours of the Larynx. MOLLIERE: Laryngotomy in a case of Epithelioma. CACCIOPOLI: First Extirpation of Larynx in Naples. DEMONS: Extirpation of the Larynx. MAYDL: Prognosis of Extirpation of Larynx. RUAULT: Examination of Larynx and Nose of Leper. MASSINI: Motor Centres of the Larynx. FASANO: Contribution to study of Laryngeal Chorea. SIMANOWSKI: Vibration of Vocal Cords in Paralyses of Different Muscles of Larynx. WAGNIER: Nodules of the Vocal Cords. ESPINA y CAPO: Laryngeal and Pulmonary Tuberculosis. OLTUSCHEWSKY: Lactic Acid in Laryngeal Tuberculosis. WOLFENDEN: Intubation of the Larynx. CARDONE: Review of Laryngological Clinic of Prof. Massei. LUCAS: Syphilitic Gumma of Trachea. LUC: Notes on Case of Fœtid Tracheitis.

Neck, &c., p. 167.—MUNK: The Thyroid Gland. HAHN: Method of removing Goître. ZESAS: Fifty Excisions of the Thyroid Gland. ZIEM: Abscess of the Lachrymal Sac. OSBORN: Staining of Skin from Nitrate of Silver. WALLER: Pulmonary Paresis. HUTCHINSON: Lectures on Lupus.

Association and Congress Meetings, p. 170.—Ninth International Medical Congress. S. S. Bishop: Pathology of Hay Fever. R. H. THOMAS: Causes and Treatment of Hay Fever. F. E. WAXHAM: On Intubation of the Larynx. M. H. RICHARDSON: Operations on the Œsophagus.

Societies, p. 179.

Reviews, p. 185.—GERDIS: The Causes of Stuttering and the Natural Cure. BRESGEN: Krankenbuch für Rhino-laryngologen. HERYNG: The Curability of Laryngeal Phthisis.

Notes, p. 186.—Dr. S. Solis-Cohen.

The Throat and Voice.

LONDON.] APRIL. [1888.

Chlorate of Potash Tabloids.

FOR AFFECTIONS OF THE VOICE, THROAT, AND RESPIRATORY SURFACES GENERALLY.

By using these Tabloids the drug is effectually brought in contact with the oral mucous surfaces as a continuous gargle, and its specific action made certain. In acute sore throat, Chlorate of Potash "usually relieves the uneasiness in a few hours" (Cohen). "It is used in ulcerated mouth and follicular pharyngitis, and has been employed in croup, diphtheria, and spasm of the larynx" (Brunton).



Retail price, 6d.

"Of convenient size, they are beautifully made; and, as they dissolve slowly in the mouth, are well suited for throat affections."—The LANCET.

Supplied in beautifully graven white metal boxes, blue silk label, to the medical profession, 30 for 4d., and 100 for 9d. Retail prices 6d. and 1s. Sent by post on receipt of price.

Chloride of Ammonium Tabloids.

The solvent and discutient as well as antiphlogistic powers of Chlorate of Potash are well known, and have led to its extensive employment, especially in Germany, in cases of sore throat and bronchitis attended with abundant secretion of thick and tough mucus or phlegm. Physicians will at once appreciate the great advantage to their patients of the local effects of this salt slowly dissolving and coming in direct contact with the inflamed surface. It at once mitigates the cough or irritation, and lessens expectoration. Two or three of the Tabloids will sometimes entirely relieve coughs that have long resisted treatment with ordinary remedies. One may be dissolved occasionally on the middle of the tongue, not near the tip.

Supplied to the medical profession in oval bottles, at 4s. 6d. and 12s. 6d. per doz. Retail prices, 6d. and 1s. 6d. Sent by post on receipt of price.

Sal Prunella Tabloids.

"A popular remedy, sometimes successful in mild cases of incipient inflammatory sore throat, is a small piece of nitre allowed to dissolve slowly in the mouth" (Waring). An excellent saline for throat cases, having very marked local efficacy when slowly dissolved on the tongue. It is a popular remedy, and for mild inflamed sore throat its ancient reputation is deserved."

Directions.—One or more (5 gr.) Tabloids should be dissolved slowly in the mouth for the local effect.

Supplied to the medical profession in bottles of 100 at 1s. 10d. Retail price, 2s. 6d. Sent by post on receipt of price.

Tabloids of Compressed Chlorate of Potash with Borax.

CHLORATE OF POTASH is proverbially known to quickly relieve hoarseness, irritation of the throat and bronchi, and when taken early may avert a cold.

BORAX has a high reputation for hoarseness and "clergyman's sore throat" (Waring). It is prescribed for aphonia and over-use of the voice (Ringer), diphtheria (Budd), aphthous ulceration in phthisis (Watson), and cracked tongue (Brunton).

It is preventive of catarrhal troubles of the nares, throat, and larynx, and for those about to speak or sing is excellent to clear the voice.

The Tabloids afford an agreeable form in which to prescribe Borax.

Potash, and Potash and Borax Tabloids supplied in beautifully graven white metal boxes, pink silk label, to the medical profession, 30 for 4d., and 100 for 9d. Retail prices, 6d. and 1/-. Sent by post on receipt of price.

Voice Tabloids.

The Voice Tabloids contain COCAINE, CHLORATE OF POTASH and BORAX.

CHLORATE OF POTASH is acknowledged to be of the greatest value in affections of the mouth and throat, relieving hoarseness, subduing inflammation, and sweetening the breath.

BORAX is highly esteemed for clergyman's sore throat, aphonia from over-use of the voice, diphtheria (Budd), aphthous ulceration in phthisis, and cracked tongue. Not only is it preventive of diseases of the nares, throat, and larynx, but taken a few minutes before speaking or singing will clarify the voice.



Retail price, 1s.

Cocaine has been much employed by throat specialists, and is highly valued in many affections of the pharynx and larynx. It allays irritability, and when not employed in too large doses, fuller, clearer, richer tones are alleged to follow at once upon its use. It relieves the dysphagia of phthisical laryngitis, and, indeed, pain in the throat from any cause whatever. The most agreeable form in which to prescribe Cocaine is in the Voice Tabloids with Chlorate of Potash and Borax.

Voice Tabloids supplied to the medical profession in beautifully graven white metal boxes, blue silk label, at 8d. and 1s. 4d. Retail prices, 1s. and 2s. Sent by post on receipt of price.

BURROUGHS, WELLCOME, & CO., Manufacturing Chemists,

SNOW HILL BUILDINGS, LONDON, E.C.

THE
JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. APRIL, 1888. No. 4.

The Editors invite original contributions.

Fifty Reprints will be supplied to each author gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

THE ACTION OF CAUSTICS ON THE NASAL MUCOUS MEMBRANE.[1]

By DR. FRANCKE H. BOSWORTH.

IN order to understand the application of caustics to the hypertrophied nasal mucous membrane, we must first form a clear idea of the pathological conditions which we wish to overcome. An hypertrophic rhinitis is the result of certain changes in the mucous lining of the nose. These changes do not affect the epithelial layer at all ; the submucosa suffers, if at all, only a slight dilatation of its blood-vessels. It is in the third, or deeper, or cavernous layer, that the important changes take place. Here we have a dilatation of the venous sinuses, increased blood supply, hypernutrition, and a consequent increase of all the elements of the intervenous connective tissue.

Again, this hypertrophy does not lead to increased secretion, as is so often supposed. It is the function of the venous sinuses to pour into the nasal cavities about sixteen ounces of clear serum daily, for the purpose of moistening the air before it enters the lungs. This clear serum, mixed with the normal mucus secreted by the lining membrane of the nose, forms a bland and non-irritating fluid, whose presence we are not cognizant of in a state of health. Diminish the diluting serum, by thickening the walls of the vessels, and the secretion becomes thick and gives annoyance.

From what has already been said, it is evident that the object of treatment should not be to destroy tissue, but to constrict the blood-vessels, diminish the nutrition, and thus counteract hypertrophy. We have found that the deep cavernous layer, by furnishing an increased blood supply, is the primary seat of the trouble. No destructive agent, applied as we are in the habit of using them in treating the nasal mucous membrane, can cause necrosis of more than the superficial epithelium, and possibly, to a very slight degree, of the submucosa ; it does not affect the deep or cavernous layer, which is the one chiefly concerned. To what, then, is the beneficial action of a caustic application due, for they certainly are of great benefit.

[1] A paper read at the Medical Society of the State of New York, February 7, 1888.

Until quite recently our caustic applications were effective simply by the contraction of the superficial slough formed. By this contraction the calibre of the venous sinuses was diminished, and the walls of the vessels enabled to regain their proper tone. Since the discovery of the wonderful power which cocaine has of contracting blood-vessels, our caustic applications have been much more efficient. The ordinary procedure is, by an application of cocaine, to deplete the vessels by diminishing their calibre; then by applying our caustic to the most prominent points, to put down this already contracted tissue by the formation of a superficial slough, maintain the vessels in a state of contraction until they can regain their normal tonicity, and thus control nutrition.

What agent shall we use to accomplish this purpose? Shall we resort to the various chemical agents, or to the potential cautery? The effect is the same in either case. For a considerable time I have used chromic acid to the exclusion of all other agents. Its advantages are so well expressed by Dr. Squibb, in the *Ephemeris*, July, 1883, that I venture to insert the quotation in full:—

"It is, perhaps, the most important and most valuable of all the erosive caustics, for one simple and characteristic reason, namely, that it is self-limiting in its action, to a degree that no other destructive caustic is. It is an active oxidizing agent, and destroys the tissues to which it is applied by oxidation. Thus far, its action is similar to other caustics, such as nitric acid, for example. But every molecule of chromic acid which destroys a molecule of organic tissue, is itself destroyed, and rendered inert by being reduced to an insoluble and inert oxide of chromium, and this principle and degree of self-limitation is not obtained from any other caustic. Sulphuric acid is also a destructive caustic, but not in the same way or by the same reaction as chromic acid, and it is not self-limiting. Both sulphuric acid itself, and the products of decomposition by it, are more continuously and injuriously irritant. It is, therefore, a more painful caustic than chromic acid, produces deeper, more prolonged, and more irritable sloughing. Hence it is that sulphuric acid is a painful caustic, while chromic acid is not. That is, both may produce severe pain, and, possibly, for a short time, equally severe pain, but the self-limiting action of the chromic acid carries its self-limiting effect to the pain also, so that both the action of destruction, and the pain also, are comparatively soon over, and the vital processes go on to separate the slough at once, and with little secondary or after irritation."

We have, then, in chromic acid an agent which fulfils all the indications. The extreme nicety with which it can be applied, without cumbersome or expensive apparatus; its efficiency, and the absence of unpleasant effects, following its intelligent use, have been sufficient to commend it to me, to the almost total exclusion of other agents. It has been claimed that cicatrices result from its use, but I have never observed them. It seems almost paradoxical to control a morbid process by a destructive agent, but at the present stage of our research we possess no better method.

ON INTUBATION OF THE LARYNX.[1]

By Dr. J. O'Dwyer.

Intubation of the larynx has been already practised in the adult in the following diseases, viz.: Erysipelas of the larynx, laryngeal diphtheria, perichondritis, neoplasm, tubercular laryngitis, several cases of syphilitic stenosis, and in two cases to get rid of retained tracheal canulas, fifteen patients in all. The operators besides the author were Dr. J. J. Reid, Dr. Dillon Brown, Dr. C. D. Cocks, of New York, and Dr. Stockton, of Chicago. Secretions never dry in the laryngeal as they do in the tracheal canula, and the author has never found it necessary to remove a tube from the adult larynx for the purpose of cleaning, which is sometimes necessary in children. The patient soon becomes aware of any accumulation of mucus, and expels it by a voluntary act of coughing. There is the same difficulty in swallowing after intubation in adults that is met with in children, and the same difference in the ability to swallow solids and liquids. Some patients swallow remarkably well from the beginning, while others find the greatest difficulty in taking anything until the tube has been in the larynx for some time. The length of time that a tube should be allowed to remain in the larynx in chronic stenosis will depend on the amount of irritation and interference with deglutition which it produces.

A large number of recoveries from diphtheritic croup following intubation have been cited by the author, in which the average time the tube was retained was much less than that required for the retention of the tracheal canula in the same disease, which proves that suspending the respiratory movements of the glottis for even a short time is injurious. In one operation the intensely inflamed larynx is kept in use by placing in it a foreign body, with restoration of its functions sooner than in the other where it is allowed to rest, by creating a new channel for the entrance and exit of air.

This view is still further confirmed by the following passage from Holmes' *System of Surgery*, vol. ii., page 36: "When a canula has been worn for any considerable time, the cavity of the larynx becomes so much contracted that it is necessary in many cases, if not in all, for respiration to be carried on through the artificial opening."

The experience with intubation in the adult has an important bearing on the question of the danger from the entrance of food through the tube—one of the alleged causes of the catarrhal pneumonia that so frequently complicates croup after operative interference. In none of the cases of chronic stenosis so far reported has there been the least evidence of pulmonary disturbance from this cause, although tubes have been worn continuously for two weeks, three weeks, in one case two months, and in another ten months.

The difference is explained by the fact, that in one class of cases the disease is confined to the larynx, while in the other the lower air-passages are almost always involved to a greater or less degree.

[1] A paper read at the Medical Society of the State of New York, February 1888.

A tube in the larynx therefore is a factor in the causation of pneumonia only in so far as it impairs nature's method of removing secretions from the bronchi by keeping the glottis open, and thus preventing that condensation of the air which is essential to give full effect to the act of coughing, and the same argument will apply with equal if not greater force to the opening in the trachea.

NEW INSTRUMENTS AND THERAPEUTICS.

PORCHER, W. P. (Charleston).—**A Self-Retaining Uvula and Palate Retractor.** *Med. Record, January* 14, 1888.

AN ordinary palate hook has a slide attachment, and from the front of this slide two arms project, ending in two medium-sized rings, which rest on either side the nose, and are retained there by counter pressure of the retracted palate. An automatic spring catch fixes the slide. The instrument is simple and effective, and has been highly commended.

Wolfenden.

ROSER, KARL (Marburg).—**A Fixable Laryngoscope.** *Centralblatt für Chirurgie*, 1887, No, 29.

A SIMILAR instrument to the one early described by v. Bruns in the early laryngoscopic days. In spite of the recommendations repeated from time to time, fixable laryngoscopes can never come into use, because it is under all circumstances absolutely necessary to frequently remove the laryngoscope for cleansing and warming. **Michael.**

A New Apparatus for Laryngoscopical and Other Examinations by Electric Light. *British Medical Journal, December* 17, 1887.

A DESCRIPTION by the Vienna correspondent of the Journal of an apparatus invented by Docens S. William Roth, of Vienna, and made by J. Leiter of that city. It is stated to be both cheap and effective.

Hunter Mackenzie.

KITCHEN, J. M. W. (New York). — **The Intra-Nasal Plug.** *Med. Record, January* 7, 1888.

THIS consists of a core of thin sheet tin, cut with a pair of stout shears to the size and shape required. This is wound with absorbent cotton to the desired thickness, and padded in particular parts. This plug is sufficiently stiff to be inserted into almost any part of the nasal cavities, and is still flexible. The cotton is saturated with any desired medicament, the plug introduced by dressing forceps, and left *in situ*. Attempts to obtain intra-nasal dilatation can be much aided by using this plug, and pressure can be obtained by moulding the tin to any spot desired. **Wolfenden.**

BRAUN (Triest).—**The Application of Chromic Acid to the Larynx.** *Internat. Klin. Rundschau*, 1887, No. 50.

TWO cases of small polypi cured by application of chromic acid.

Michael.

BARBOT.—The Treatment of Whooping-Cough by Intra-Nasal Insufflations of Antiseptic Powders. *Thèse, Paris*, 1888.

A THESIS inspired by Dr. Moigard, who is making general, in France, the treatment of whooping-cough by nasal insufflations, and in which the author makes a very interesting bibliographical study of the question. He says that the treatment shortens the duration of whooping-cough, diminishes the number and violence of the coughing attacks, and causes the vomiting and hæmorrhage to cease. An important work. Joal.

SWETT, W. P. (Terryville, Conn.)—**Insufflations of Quinine, in Whooping-Cough.** *Med. Record, January* 7, 1888.

THIRTY cases, all under ten years of age, were much benefited by morning and evening insufflations; paroxsyms being lessened, sleep and appetite improved. Sulphur fumigations also afford relief. Wolfenden.

WITHERLE, C. B. (St. Paul, Minn.) — **Sulphide of Calcium in Pulmonary phthisis.** *Med. Record, January* 7, 1888.

A RECOMMENDATION of administration of this drug in commencing phthisis. Beginning with half grain in pill form every two hours, it may be increased up to one grain. The author has found it relieve several cases of obstinate cough, without pulmonary lesion. Wolfenden.

FILLEAU & PETIT.—An Inhalation for Phthisis. *Rev. du Thérapeutique, December* 1, 1887.

Carbolic Acid	gr. 30
Essent. Terebinth....	ʒ 12½
Essent. Picis	ʒ 5
Eucalyptol	ʒ 7½
Chloroform	gtt. 5

To be inhaled four to six times daily, for five minutes at each sitting.

Wolfenden.

ALVIN.—Iodoform in the Treatment of certain Anorexias and Dysphagias. *Loire Médicale, September* 15, 1887.

FOR dysphagia caused by ulcerative conditions of the upper respiratory tract (pharynx, larynx, etc.), and accompanied with anorexia, the author recommends—

Iodoform...	1—2 grammes.
Sweet oil of almonds	800 grammes.
Essence of bitter almonds	2—4 drops.

Three spoonfuls a day to be administered, one on waking, and one before each principal meal. The iodoform cures the anorexia produced by the introduction into the stomach of secretions which the patient is unable to reject. Dr. Alvin relates two cases supporting his plan of treatment, and Dr. Emend has reported favourably of the same. Wolfenden.

SOLUTION OF CHLORIDE OF ZINC.—*Journal de Méd., November 27, 1887.*

A PERFECT solution for external use is obtained by using the following formula :—

Zinc chloride	ʒ x.
Distilled water	O ij.
Pure hydrochloric acid	♏ xlv.

Wolfenden.

DIPHTHERIA.

SCHRAKAMP (Hamburg).—**On Organic Pathological Degenerations in Diphtheria.** *Archiv. für Kinderheilk.*, 1888, *Bd.* 9, *Heft* 3.

THE author has made autopsies in fifty-four cases of diphtheria, and has noticed the pathological condition of the different organs with the following results. Diphtheria of the mouth was seen in two cases ; the pharynx was infected in forty-one cases ; diphtheria of the nose occurred in eleven cases ; of the œsophagus in three cases ; stomach and intestines in one case. The larynx and trachea were affected in fifty-one cases ; true membranes occurring in thirty-nine cases (the others were catarrh). In forty cases was found bronchitis ; in thirty-one cases the lungs were also affected with pneumonia. Nineteen of these cases were complicated by emphysema ; nine by atelectasis. Pleuritis occurred in nineteen cases, pericarditis fourteen times, endocarditis only twice, thrombosis twice, myocarditic degenerations in seventeen cases. The kidneys were in a pathological condition in twenty-two cases, exhibiting the affection called by Furlinger acute infectious desquamative nephritis. Lymphadenitis occurred in forty cases, diphtheria of the skin and the genital organs was seen only once ; hæmorrhages of the skin occurred in four cases. Death was caused in nearly all cases by affections of the respiratory organs.

Michael.

WERNICKE.—**True or False Croup.** *Revista Argentina de Ciencias Medicàs, August*, 1887.

FROM observations upon six cases the author thinks himself entitled to maintain that a child has false croup when he coughs hoarsely and speaks clearly.

Sota y Lastra.

TOMÉ COSPÉDAL.—**Diphtheria.** *Anales de Obstet. Ginecopatia y Pediatria, January*, 1888.

THE author advises the use of perchloride of iron internally, and of pure hydrochloric acid locally.

Sota y Lastra.

SCHMEIDLER (Breslau).—**On the Treatment of Diphtheria** *Breslauer Aerzte Zeitsch.* 1888, *No.* 4.

THE author recommends local treatment, especially with turpentine.

Michael

SCHUCHARDT (Gotha).—**Historical Essay on Tracheotomy in Croup and Diphtheria, especially in Germany.** *Langenbeck's Archiv*, Bd. 36, Heft. 3.

REPORT upon the literature and development of the operation, and an enumeration of 317 cases of tracheotomy performed in Germany from the beginning of the operation to 1863 (91 cures, or 29·34 per cent.).

Michael.

SOTA Y LASTRA.—**Thirteen Cases of Croup treated by Intubation of the Larynx.** *Revista Med. de Sevilla, December* 31, 1887.

IN a Conference held at the School of Medicine at Seville, the author referred briefly to reports of thirteen intubations, and founding his conclusions upon them, said, that if the introduction of the tube is not always easy it is not dangerous when operating with prudence; one ought not to employ much force nor occupy much time. The sliding of the tube into the stomach is not dangerous, and pushing forward of the membrane is very rare. The obstruction of the tube is very seldom complete; when so, it should be withdrawn, unless thrown out by coughing. When this occurs there is time to call the doctor to replace it before asphyxia takes place. He has always found the tube much easier to withdraw than to introduce, in spite of what many writers say; he therefore does not understand how life is endangered by inability to withdraw it at the proper moment. The deglutition of solids is well effected, and the injuries caused by the sojourn of the tube in the larynx are much less grave than those caused by the tracheotomy canula. He believes that aphonia depends on the disease and not on the operation. He adds at the conclusion another case observed after the conference above referred to, and his results show that of the fourteen cases thus treated four were cured. **Sota y Lastra.**

GREENWOOD, MAJOR (Haggerston). — **A Case of Laryngeal Diphtheria.** *British Medical Journal, December* 17, 1887.

PARTURITION occurred whilst the patient was suffering from the disease. The child was still-born, and the mother died five days subsequently. "Her throat, and I examined it every day, was not notably affected, nor was there any sign of diphtheritic exudation; but the gland of the neck, behind the angle of the jaw, was distinctly enlarged. Her temperature, except on the first night, was strictly normal throughout." The urine was albuminous; the sputum was bloody and membranous-looking; the larynx was tender on palpation; and there was extreme prostration. On examination of the larynx after death, there was intense congestion of all its structures, especially the epiglottis; there was slight narrowing of the rima glottidis; the mucous membrane in places was almost gangrenous; and there were several deep ulcers, one especially over the left vocal cord. On floating the part in water it was ascertained that the mucous membrane of laryngeal trachea (*sic*) was covered by a film of membrane." The author concludes that the history and lesions pointed to a virulent form of diphtheria.

Hunter Mackenzie.

NOSE AND NASO-PHARYNX.

HERZOG (Graz).—**Eczema of the Nasal Orifice.** *Archiv. für Kinderheilk., Bd. ix.*

IN the greater number of cases the eczema is combined with scrofula. In all cases the author has found chronic rhinitis co-existent. The affection is sometimes complicated by erysipelas or furunculosis. The author relates six cases of this complication. In adults the affection is sometimes not easily differentiated from sycosis. The treatment consists in applications of ointments, of yellow oxide of mercury and vaseline with lead. **Michael.**

VRUNNELA.—Several Cases of Intermittent Dyspnœa of Obscure Pathogeny. *Revista de Medicina y Cirugia Practicas, February* 7, 1888.

DR. VRUNNELA, in the Spanish Medical and Surgical Academy, quoted some cases from which he deduced that there are many morbid conditions of the nasal fossæ, pharynx, and larynx, which may produce intense dyspnœa, and which may even necessitate tracheotomy. **Sota y Lastra.**

RUAULT.—Reflex Neuropathies of Nasal Origin. *Gaz. des Hôp., December* 10, 1887.

REVIEWS the question in an excellent manner. A very complete and erudite study. **Joal.**

BROWN, M. R. (Chicago).—**Paroxysmal Sneezing.** *British Medical Journal, December* 10, 1887.

THE writer recommends examination of the nasal mucous membrane for super-sensitive areas. These should be destroyed with the galvano-cautery. Atropine, $\frac{1}{100}$th grain once or twice daily, or the local application of a 4% solution of cocain may give temporary relief.
Hunter Mackenzie.

COEN (Wien).—**Rare Cases of Nasal Speech.** *Archiv für Kinderheilk, Bd. ix., Heft* 3, 1888.

NASAL speech caused by hypertrophy of one posterior nasal concha.
Michael.

SOURDRILLE.—Contribution to the Study of Reflex Neuroses of Nasal and Naso-Pharyngeal Origin. *Thèse, Paris, December,* 1887.

THIS work, by one of Gougenheim's pupils, is very incomplete. We would advise the author to familiarize himself with the treatment of nasal affections from a bibliographical point of view. He would benefit by reading A. Ruault's recent work. **Joal.**

GARRIGOU-DÉSARENÈS.—Chronic Catarrh of the Nasal Fossæ, and its Treatment with the Chemical Galvano-Cautery. *Paris*, 1888.

THE author describes in this work the method which he was the first to employ, and the results he has obtained since 1884, when he commenced to practise it. After having studied the physiology and anatomy of the nasal fossæ, described the method of inspection and the instruments used, and given an account of chronic catarrh, hypertrophic, atrophic, and of adenoid vegetations, on which chapter we have no remarks to make, Garrigou Désarènes reviews the different methods employed in chronic catarrh, and condemns the employment of cauterization with chromic acid or nitrate of silver, and the use of the galvano-cautery and bistoury. He points out their defects, and enumerates the inconveniences that may result from their use. (Similar consequences, he says, cannot be attributed to the chemical galvano-caustic, for it acts gently and slowly, and is not painful to the patient, which superiority alone should weigh in its favour, and render its use preferable.) He then describes in detail the method of using it, insists on the application of the poles in a particular way, on the length of treatment, &c. Finally, he contributes the results obtained in his private practice, and in his clinic of the Boulevard St. Germain. In hypertrophic catarrh, after the three first applications the patient generally is sensible of relief from the electric current, and in the majority of cases after ten applications the cure of the catarrh is complete. In ozæna, after some days of the treatment the smell disappears, and notable amelioration is experienced ; one can even see the nasal cavities partly return to their primitive dimensions by a sort of regeneration of the mucosa, which resumes its normal aspect, and is coloured a pinkish grey. The author has seen a certain number of patients cured in a comparatively short space of time without recurrence more than a year afterwards. In adenoid tumours continuous currents may suffice to obtain a cure when the tumours are not much developed. It is well to employ the chemical galvano-cautery after the sanguinary operation, to prevent the development of new vegetations. Finally, Garrigou-Désarènes says that he has frequently treated traumatic epistaxes successfully by the action of continuous currents, and he then recommends the use of the positive pole, which possesses an undeniable hæmostatic power. **Joal.**

LEFLAIVE.—Summer Asthma. *Thèse, Paris, December*, 1887.

THE author calls the affection annual rhino-bronchitis or summer asthma, because these denominations do not in the least prejudge the etiological condition, whilst they are sufficiently clear to indicate the disease without ambiguity. He describes an oculo-nasal form (weeping, itching of the eyes, redness of the conjunctiva, photophobia, nasal flow aqueous at first, then yellow and thick, and spasmodic sneezing), and an oculo-naso-thoracic form, in which asthmatic dyspnœa is superadded to the previous symptoms, without expectoration at first, then accompanied with cough and expectoration. Summer asthma appears for the first time at ages varying from fifteen to thirty ; it returns annually at the same time,

and is reproduced every year without exception. Age appears to diminish the attacks. The masculine sex is more susceptible to it. The malady is often hereditary, and appears to have an etiological relationship to gout; thus is explained its frequency in the Anglo-Saxon races, and its rarity in the hospitals. Its determining cause is the return of summer, which acts by meteorological influences, probably complex, difficult to determine. At any rate, the author holds that the nasal origin of summer asthma is far from proved. (Our personal opinion is based on a relatively small number of facts, but amongst them is nothing to authorize our thinking that a nasal lesion is the starting point of the malady.) A conscientious work, the conclusions of which we cannot, however, accept. **Joal.**

BOND, J. W. (London).—**Cases of Mucous Polypus in the Child** *British Medical Journal, December*, 10 1887.

THE first case is that of a girl, aged fifteen years, who had suffered from nasal polypus for about four years. It was now removed by the cold snare. The second is that of a girl aged eight, from whom a large mucous polypus of the nose was successfully removed under chloroform, *viâ* the mouth, by means of the *ecraseur*. As an appendix, there is narrated the case of a woman, aged thirty, in which a large mucous polypus sprang from the posterior end of the middle turbinated bone, and completely filled up the post-nasal region. It was successfully removed by the *ecraseur* and by forceps. **Hunter Mackenzie.**

NOQUET.—Foreign Bodies in the Left Nasal Fossa, causing Fœtid Rhinitis. *Soc. Méd. de Lille, November* 29, 1887.

RHINITIS, with a particular odour, with a different fœtidity from that of ozæna, produced by a wooden button which represented a cylinder eight millimètres in diameter and nine millimètres in height. This foreign body was in the left nasal fossa, a centimètre behind the anterior extremity of the inferior turbinated body. It was easily removed by Noquet, who saw that the mucosa was very red at the point of contact, was swollen, and bled very easily; the button was covered with a thin layer of calcareous matter. The extraction of the foreign body caused cessation of all the symptoms. **Joal.**

BOUCHER, G.—A Case of Considerable Deviation of the Nasal Septum, producing Complete Stenosis of One Naris. Recovery with Compressed Air. *Archivi Italiano di Laringologia*, 1888.

A VERY interesting contribution to the treatment of such conditions by a simple method, first recommended by Prof. Massei. The deviation was so intense that the patient, a child ten years old, could not breathe through the right naris, and the point of the nose was deviated to the left side. The case certainly indicated surgical treatment; it was a very typical one, and the abstractor recommends, especially, those American rhinologists who have such large experience of surgical treatment of this kind to try nasal douches of compressed air with Waldenburg's pneumatic apparatus **Massei.**

VERCHÈRE.—Operative Indications in Certain Recurrent Tumours of the Cavity and Posterior Nasal Fossæ. *Archives de Laryngologie, November*, 1887.

THE author relates two observations, one of naso-pharyngeal tumours cured by slow destruction with the thermo-cautery after palatine incision; the other of globo-cellular sarcoma of the nasal fossæ and naso-pharynx removed through the nose after incision; he concludes that in all cases where a tumour situated in the nasal cavity or naso-pharynx is inaccessible *per vias naturales*, it is necessary to have recourse to a preliminary operation through the palate for naso-pharyngeal polypi, and median incision of the nose for tumours of the nasal fossæ.

Joal.

HOPMAN.—On the Author's Method of Removing Tumours of the Naso-Pharynx by Combined Bilateral Operation. *Monatschr. für Ohrenheilk.*, 1888, No. 1.

RECLAMATION of the priority for this method against Zaufal, to whom this method is attributed by Ziem.

Michael.

CARTAZ.—On the Persistence of Phonetic Troubles after the Ablation of Adenoid Vegetations. *Archives de Laryngologie, Dec.*, 1887.

IT is well known that the obstruction of the pharyngo-nasal cavity greatly diminishes the resonance of the voice, the timbre of which becomes muffled and veiled. Besides this, it prevents the clear enunciation of the nasal sounds; the "Ms" and "Ns" are transformed into "B"; these troubles in speech generally disappear from the moment that the pharyngo-nasal cavity is restored to its normal calibre, and that the vegetations are extracted or destroyed. But this is not always the case, and Cartaz has observed in two little patients, on whom he performed ablation of the vegetations, with Lœwenberg's forceps, a rather pronounced persistence of the nasal twang. These phenomena are caused by a paresis, a defect of accommodation of the arch of the palate, through its prolonged inaction due to the presence of the tumours. These troubles are similar to those one notices in persons suffering from fissure of the arch or vault of the palate, and it becomes necessary, by a supplementary education, to remedy the imperfections of speech. Cartaz, in cases of adenoid vegetation, insists besides on the utility of reading aloud, articulating each syllable distinctly, and emphasizing each word; he also recommends teaching by the solfeggi, holding each note for some time, and, finally, electrisation of the arch may produce good results.

Joal.

MOUTH, TONSILS, PHARYNX, &c.

PORTER, R. (Medical Staff).—**Communicability of Syphilis through the Saliva.** *British Medical Journal, December* 10, 1887.

RECORD of a case of tattooing, in which a syphilitic operator spat on the arm of his subject and then rubbed it, in order to remove the blood which

flowed at each puncture of the needle. Syphilitic sores, which looked like chancres, followed at the seat of operation within a week, and within eight weeks a copious rash of a specific character appeared over the whole of the body. Antisyphilitic treatment was followed with success.

Hunter Mackenzie.

LECKIE, D. (Medical Staff), **CARLETON, P. M.** (Medical Staff).—**Communicability of Syphilis through the Saliva.** *British Medical Journal, December* 24, 1887.

THE former believes that, in all cases where syphilis has been communicated through the saliva, it is owing to the admixture of this with the contagious secretion from mucous patches.

The latter narrates a case of syphilis following tattooing similar to that already recorded by Surgeon Porter (*vide antea*). (It is worthy of note that in this latter case the infecting saliva is stated to have been derived from a soldier with well-marked *tertiary* syphilis.) **Hunter Mackenzie.**

PAGE, FREDERICK (Newcastle-on-Tyne).—**Closure of the Jaws from Ankylosis of the Left Temporo-Maxillary Joint successfully treated by Excision of the Condyle of the Lower Jaw.** *British Medical Journal, December* 10, 1887.

THE nature of the case is indicated by the title. **Hunter Mackenzie.**

DESCROIZELLES.—Œdema of the Glottis, Œsophagitis, Acute Gastro-enteritis, caused by Ingestion of very hot Soup. *Gaz. des Hôp. December* 27, 1887.

THE patient, a child aged nineteen months, died thirty hours after having absorbed the liquid. At the autopsy a projecting whitish plaque was found above and at the right of the epiglottis, also on the ary-epiglottic fold, caused by a local infiltration of the sub-mucous tissue, and a centimètre and a half in length. A similar but smaller plaque occupied the left part of the epiglottis, towards the base of the tongue. Besides this, signs of œsophagitis and gastro-enteritis were present. **Joal.**

TRÉLAT.—Epithelioma of the Tongue, Roof of the Mouth, and Anterior Pillar of the Palatine Arch. *Gaz. des Hôp., November* 17, 1887.

IN a lecture given at the Hôpital de la Charité, the professor advised caution in the cases (1) of persons in whom a bilateral glandular swelling insidiously developes, differing from scrofula or tuberculosis, such origin being ignored. This kind of swelling is often the first symptom of cancer. (2) Of persons who have reached or passed the age of forty, fifty, or sixty years, in whom a glandular swelling suddenly appears without appreciable cause and progresses rapidly. This class of patient belongs to the same type as those who have difficulty in swallowing and speaking, and experience great pain in the ear. **Joal.**

VERNET.—Case of Nigritis of the Tongue. *Gaz. des Hôp., December* 31, 1887.

THE author observed this case, which happened to himself, and was of

interest, as the tongue became black in the course of herpetic angina; the nigritis increased with the production of new vesicles, and disappeared with them, which seems to favour the theory that the affection has a parasitic origin. However, the microscopical examination made at different stages of the malady did not show the slightest traces of parasitic elements. **Joal.**

LEUDET.—Hemiatrophies of the Tongue, of Syphilitic Origin. *Annales des Mal. Oreilles et Larynx, December*, 1887.

THE author relates two observations, obtained at the Lariboisière Hospital, of hemiatrophy of the tongue caused by syphilis. The patients had at the same time paralysis of the corresponding vocal cord, and he passes in review the different kinds of lingual hemiatrophies, and sums up the most interesting of the observations known. (Ballet, Eisenlohr, Byron-Bramwell, Hirt, Schiffers, Clarke, Erb, Lande, Remak). **Joal.**

LE BEC.—Epithelioma of the Tongue and Arch of the Palate; Resection of the Maxilla; Ligature of the Lingual; Preliminary Tracheotomy; Death from Pulmonary Complications. *Journal Médecine, November*, 27, 1887.

SEVERAL authors maintain that the air passing through the mouth of any one who has just had a serious operation, exposes the patient to septic pneumonia, and they perform tracheotomy to protect the patient from a similar accident. But observation shows that patients often die from pulmonary accidents, owing to the too cold air which passes through the canula. The present case is an instance. **Joal.**

GRIFFIN, E. H. (New York).—**A Case of Complete Adhesion of the Soft Palate to the Pharynx, with an Operation for its Cure.** *Med. Record, January* 14, 1888.

THE patient had complete paralysis of the abductors of the vocal cords, extensive ulceration of the nose, destruction of uvula and soft palate, with complete adhesion of the residue of the latter to the pharynx. The operation for relief consisted in passing a probe down the nose to the pharynx, and with a tenotomy knife cutting where the palate bellied, and separating the palate from its attachment. The wound was then kept from closing by passing as large sounds through it as could be applied. The parts healed well. One hundred grains of iodide of potash three times a day were necessary before any effect could be produced by the drug. The author does not consider this an unusually large dose, having often given larger doses, and maintained them for longer time. An artificial nose was supplied to the patient, who was dismissed with one of the pharyngeal sounds, with instructions to use it once or twice a week for a year. **Wolfenden.**

MATIER.—Adenoma of the Arch of the Palate. *Revue Mensuelle de Laryngologie, November*, 1887.

TUMOURS of the palatine vault and of the arch of the palate, particularly benign tumours, being somewhat rare, the author has thought it interest-

ing to publish a new case of adenoma observed in the hospital at Bordeaux, in the clinic of Dr. Demons. The tumour had the size and shape of a hen's egg; at the posterior extremity it occupied the right side of the vault, outwardly it followed pretty accurately the curvature of the dental arch, and the front terminated at the level of the first molar tooth; it appeared to be attached to the arch by a large pedicle, but it had more the appearance of a sessile than a pedunculated tumour. There was no glandular enlargement, and its development was slow. The operation was performed by Dr. Demons, and the histological examination showed that it was an adenoma. M. Natier, after the observation, made some interesting remarks on the subject of adenomas; the origin, symptomatology, and diagnosis of these tumours are carefully studied. We congratulate the young laryngologist. **Joal.**

BLACHE.—Clinical Remarks on Hypertrophy of the Palatine Tonsils, and the Adenoid Tissue of the Naso-Pharynx. *Acad. Médecine, December* 27, 1887.

UNTIL now this affection has been the property of specialists. This ought not to be, for it gives rise to a series of symptoms that come completely within the jurisdiction of general practitioners; and with his incontestable ability in infantile pathology, the author draws a very complete picture of the accidents determined by the presence of adenoid vegetations in the naso-pharynx. **Joal.**

PREUSS (Gros-Schönebeck).—**Treatment of Polypi of the Mucous Membrane with Ergotine.**

THE author was called to a woman suddenly attacked with difficulty of breathing and swallowing. Between the uvula and the right tonsil a blue-red tumour without pedicle was found. Patient would not allow any operation. After three injections of ergotine into the tumour, and brushing with cocaine, the tumour disappeared. **Michael.**

MENDES and BONITO.—Pharyngo-Mycosis. *Thèse, Bordeaux, November.* 1887.

THIS affection is far from being rare, as some authors have thought, but is, on the contrary, of frequent occurrence, and appears to be constituted by the development of leptothrix mycosis, derived probably from leptothrix buccalis. It is a purely local affection, without inflammatory reaction on the mucosa, and is due to a particular modification of the mucosa of the pharynx, and perhaps also to a certain disposition of the glands of that region, which favour its origin and frequent occurrence. The concretions ought to be removed with a cutting curette, and afterwards the parts should be cauterized with the galvano-cautery. **Joal.**

SOTA Y LASTRA.—Ludwig's Angina. *Revista Med. de Sevilla, tomo xi., No.* 7.

THE history of a case in which general malignant symptoms were manifested before the local ones became intense. These subsided first,

and two days after the cure was complete. The patient extruded by Wharton's duct a small stone of the size and form of a grain of corn.

Sota y Lastra.

BURKHARDT (Stuttgart).—**On the Opening of Retro-Pharyngeal Abscesses.** *Centralb. für Chirurgie*, 1888, No. 4.

THE author proposes to open such abscesses of the pharynx as are very deep not from the mouth but from the neck. He has performed this operation in three cases with good results. Michael.

TESSIER.—Stricture of the Œsophagus and Tuberculosis. *Annales des Mal. de Larynx. November*, 1887.

THE cause of the stricture lies—1. In the œsophagus. 2. In its vicinity. In the first case there are troubles of deglutition as in cancer, dyspnœa, crises of suffocation, and progressive loss of flesh; this tuberculous stricture shows itself in patients from thirty-five to forty-five years old. In the diagnosis too much stress must not be placed on pulmonary signs of tuberculosis, for cancerous stricture sometimes grows out of the first signs of pulmonary tuberculosis. But when vomiting of blood takes place at the commencement of the affection, or at least at an early stage, the appearances point more to phthisis, regurgitations of blood in cancer happening at a more advanced stage. Another proof in favour of tuberculosis is the prior pulmonary lesion, the phthisis of cancerous persons being an affection of the ultimate phase. The anatomical lesions which give rise to this kind of stricture consist of one or two greenish-looking ulcerations with clean edges, little raised, situated on an indurated basis more or less prominent; thus the degree of stricture is generally slight. When the cause of the stricture is situated in the œsophagus, propagation of the tuberculosis results from contiguity or glandular compression; in laryngeal tuberculosis it is when there is perichondritis of the cricoid cartilage that the œsophagus is most liable to lesion.

Joal.

LARYNX.

CASADESÚS, ROQUER.—The Progress of Laryngology constitutes a Positive Advance in Medicine. *Revista de Laryngologia, Otologia, y Rinologia, January and February*, 1888.

IT seems incredible that it is still necessary to maintain such a thesis before a scientific society, but it is nevertheless true. Sota y Lastra.

BARON, BARCLAY J. (Bristol).—**Comments on a Case of Extremely Acute Œdematous Laryngitis.** *British Medical Journal, December* 17, 1887.

THE author considers the points of interest in the case as follow:—(1). *The extreme rapidity of onset.* Only three hours elapsed between the first feeling of pain in the ear and the development of a condition of intense laryngeal spasm and dyspnœa. (2). *Its etiology.* "It was a

case of contiguous œdematous laryngitis, which spread from a merely trifling pharyngeal congestion in a woman debilitated by rapid child-bearing and by 'cold in the head,' with the accompanying feverishness, &c., from which she had suffered for two months previously." The case was successfully treated by poultices and sedative inhalations, and by nutrient enemata. **Hunter Mackenzie.**

KOEBERLE (Strasburg).—**Polypous Tumours of the Larynx; Imminent Asphyxia; Laryngotomy.** *Allg. Wiener. Med. Zeitz.* 1887, No. 48.

THE author operates in Roser's position, with hanging head. He performs laryngotomy without previous tracheotomy, on the ground that the canula has an irritating effect. He takes care that a permanent opening by a closed canula remains in the larynx, in order to be able to treat every recurrence of the tumours without further operation. The papillary tumour, in this particular case, was an epithelioma, and was removed by a forceps, the branches of which were sharp spoons. **Michael.**

MOLLIERE, DANIEL.—Laryngotomy in a Case of Epithelioma of the Larynx. *Bulletin Médical, December* 27, 1887.

A DIAGNOSIS of the affection was made by Dr. Garel, who saw a warty tumour, as large as a walnut, occupying the arytenoid eminence and the left aryteno-epiglottidean fold. The left vocal cord was covered by the neoplasm; the right side was free. Tracheotomy was performed, and Trendelenburg's canula introduced, and the larynx was then immediately incised and the tumour removed with curved scissors. The recovery was rapid. Laryngotomy is then an operation which ought to be included in regular course of surgery at the hospitals. **Joal.**

CACCIOPOLI, Prof. G. — The First Extirpation of the Larynx Performed in Naples. *Il Progresso Medico*, 1888.

A SHORT account of the reasons for which it was decided to perform laryngotomy.

A woman, fifty-two years old, was operated upon December 14, 1887, by the same surgeon, for a large tumour (soft sarcoma) of the thyroid gland, which interfered with the breathing, and the weight of which (as stated after the extirpation) was 960 grammes. Three weeks later there was a recurrence, which was treated by Volkmann's spoon and cauterization. A later recurrence necessitated a third very difficult operation, during which the professor was able easily to convince himself that the tumour was adherent to the thyroid and cricoid cartilages and the first rings of the trachea. On February 7. a new tumour was found, involving the right half of the thyroid cartilage. Laryngectomy was decided upon, and performed on February 19. The abstractor, who had the honour of being present, is very happy to congratulate the operator. Up till now everything has progressed satisfactorily. The larynx and the first six rings of the trachea were extirpated, and it is to be hodep that the thirteenth laryngectomy practised by Italian surgeons may be crov r ed with complete and satisfactory success. **Massei.**

DEMONS.—Extirpation of the Larynx. *Acad. Médecine, December* 20, 1887.

M. DEMONS, a distinguished professor of the school of Bordeaux, relates his observations on two patients whose larynxes he extirpated, partially in the one case and totally in the other. These two patients had epithelial tumours; they were operated upon, the one in May, the other in June, and are now in a satisfactory condition. Resting on these two facts, Demons considers that extirpation of the larynx ought to be regarded as a good operation, superior in practice as well as in theory to the palliative one of tracheotomy, though recurrences, which are the breakers ahead in all operations performed for cancer, are always to be dreaded. Epitheliomas, the progress of which is slow, and which have not passed the laryngeal cavity and invaded the lymphatic system, constitute, according to the author, the most favourable cases for the operation. **Joal.**

MAYDL (Wien.).—**The Prognosis of Extirpation of the Larynx.** *Internat. Klin. Rundschau*, 1888, No. 425.

THE author related that in one of his cases, which had been free from recurrence for twenty-five months, this afterwards occurred, and he therefore believes that a case cannot be considered to be definitely cured until three years after operation, merely because recurrence has not been observed within this time. Of sixty-five cases operated on, thirty died in a short time after operation, twenty died within nine months after operation from recurrence, eight cases were at this time without recurrence, but in only two cases could it be said that a definite cure was effected (thirty-four months and four years after operation). **Michael.**

RUAULT.—Examination of the Larynx and Nose of a Leper. *Archives de Laryngologie, December*, 1887.

THE face, ears, and limbs of the patient, aged thirty-six, are covered with leprous tubercles and numerous ulcerations. There was found—1. Perforation of the cartilaginous septum, which was almost wholly destroyed; the inferior turbinated bodies were reduced to small size; the middle turbinated bodies were thick and ulcerated: the roof was a dirty yellow colour. 2. In the mouth and pharynx, the teeth were laid bare, the gums ulcerated, the palatine arch had an ulceration in the middle; there were also found two ulcerations on the left side of the tongue. 3. In the larynx, the epiglottis was very large, it had been thickened by more than a centimètre; on its free side there were badly defined or crater-like erosions, the vocal cords had lost their pearly aspect, and were yellowish and rough, and their free edges were serrated; all the larynx was the same reddish colour. The mobility of the larynx appeared diminished but not abolished. **Joal.**

MASSINI, G.—On the Motor Centres of the Larynx. *Archiv Ital. di Laringol*, 1888.

THIS is a monograph of forty-three pages, in which the author founds certain conclusions on the clinical cases published up to the present, and on

his own experiments undertaken at Florence, in the laboratory of Prof. Luciani, as follow:—

1. There is in the anterior hemispheres of man a zone which presides over the movements of the glottis.

2. This zone probably is situated in the third frontal convolution, near Broca's area and the base of the ascending frontal.

3. Lesions of this zone give rise to lasting paralysis of the glottis, aphonia, raucous voice, and diphthonia.

4. Paralysis of sensibility follows on motor-paralysis.

This latest study of the author sheds a new light on certain pathological problems; and if Massini is not always in accord with Krause, both of them have, nevertheless, the merit of having contributed much to our scientific knowledge of the subject. **Massei.**

FASANO, A.—Contribution to the Study of Laryngeal Chorea. *Bol. delle Mal. dell' Orecchio, etc.*, 1887.

Two cases are related, but the symptoms are not sufficiently marked in either. The author agrees with *Schrötter* and not with *Massei* in considering the disease as a motor and not as a sensory condition, although he employs remedies suggested by the latter, and the only argument which he claims is the application of the galvanic current. (The abstractor is of opinion that before long the term "chorea laryngis" will cease to be applied to the morbid condition so well described by Schrötter.) **Massei.**

SIMANOWSKI (St. Petersburg).—**On Vibration of the Vocal Cords in Paralyses of the different Muscles of the Larynx.** *Pflüger's Archiv*, Bd. 42, Heft. 324, 1888.

The author has studied the musical vibrations of the vocal cords in dogs. In his experiments he made use of dogs which gave musical tones while they were on the operating table.

Experiment I. Destruction of the right crico-thyroid muscle. The right cords and the right ventricle of Morgagni could be better seen than the left. The right cord, during singing, lay deeper than the left. The dog gave three tones of the bass register. The stroboscope showed sometimes alternating, sometimes synchronous vibrations of the vocal cords; on louder phonation only synchronous vibrations.

Experiment II. Resection of a portion of the superior laryngeal nerve (seven centimètres in length). The right vocal cord seemed, during respiration, to be larger than the left. The stroboscope showed synchronous vibrations during higher tones, alternating with deep tones. In higher tones the right vocal cord seemed to be longer than the left. The dog produced seven tones—*si, do, re, mi, fa. fa-dies.*

Experiment III. After destruction of both nerves or both muscles the tone produced was one and a-half octaves deeper than before. The vocal cords were like unfilled sails. The stroboscope showed synchronous vibrations.

In a case of paralysis of the right vocal cord in a man, the stroboscope showed that during deeper tones the non-paralyzed vocal cord executed

regular vibrations, the paralyzed cord resting immovable. In production of higher tones synchronous vibrations of both vocal cords occurred.

Michael.

WAGNIER.—Nodules of the Vocal Cords. *Rev. Mensuelle, February*, 1888.

In the course of acute laryngitis, or more often in the chronic form, one sometimes observes an irregularity of the edge of one of the vocal cords, or of both at a time. These irregularities, increasing, form at length on the edge of the vocal cords small nodules which occur in catarrhal inflammation. These nodules are noticed especially in persons who, by profession, speak with effort, or sing during laryngeal inflammation—lyric artistes are most prone to this affection. The site of the nodules varies wonderfully little; they are almost always to be seen towards the middle of the inferior vocal cords and nearer their anterior commisure. They seldom exceed in thickness the head of a pin: they are generally bilateral, and in this case always symmetrical and exactly facing one another; the unilateral are larger and less amenable to treatment. In the case of the small nodules, phonation is little affected in the bass tones; on the contrary, the utterance of high notes becomes an impossibility in the chest register, and can only take place in the falsetto; even this latter is very limited, and the highest notes cannot be produced. The voice is clearer in the "*forte*," and in some cases there is a simultaneous utterance of two different sounds, of which artistes are well aware; these sounds may correspond to a musical interval, *e.g.*, a third, but this is not always the case. Nodules once formed often continue indefinitely without increasing, and sometimes even disappear spontaneously; they sometimes recur after being driven away by the treatment, and can even change into real polypi. They result from an inflammatory condition, and form a hyperplasia which, limited at first to the epithelium, may include all the elements of the mucosa. Treatment—nitrate of silver, chromic acid, galvano-cautery.

Joal.

ESPINA Y CAPO.—Treatment of the Complications of Laryngeal and Pulmonary Tuberculosis. *Revista de Medicina y Cirugia Practicas, January 7 and 22, and February 22*, 1888.

In the first lecture which the author gave upon this subject in the Central Hospital of Madrid, he claimed, for arrest of hæmoptysis, essential oil of turpentine; of capillary hæmorrhages, carbolic acid; of abundant hæmoptysis, ipecacuanha and bleeding; and in either case, ergot, digitalis, sulphate of quinine, and opium, revulsive and derivative methods.

Sota y Lastra.

OLTUSCHEWSKY (Warschau).**—Contribution to the Effect of Lactic Acid in Laryngeal Tuberculosis.** *Deutsch. Med. Wochenschr.* 88, No. 8.

Communication of nine cases, with cure of the ulcers in six cases, improvement of the ulcers in one case, improvement of deglutition in one case, and negative results in one case. In slight cases the author brushes with the acid; in cases where there is infiltration he first applies the sharp spoon and then the acid.

Michael.

WOLFENDEN (London).—**Intubation of the Larynx.** *Archiv für Kinderheilk*, Bd. 9, Heft. 3.

A GERMAN translation of Dr. Wolfenden's article in the first number of this Journal, by Michael, with an appendix by the translator on additional publications upon this method since the appearance of the article.

Michael.

CARDONE.—Statistical Review of the Laryngological Clinic of Prof. Massei. *Progresso Medico (Randiconti dell' ano Scolastico*, 1886—87*). (Anno VI.)*

PATIENTS observed and treated, 1870 :—604 with inflammatory affections ; 89, syphilitic ; 61, tubercular ; 37, nervous ; 47, neoplasms : with 32 diverse cases. Amongst others occurred a case of acute hæmorrhagic laryngitis, one of primitive tuberculosis of the larynx, another of tuberculosis of the tongue. Among syphilitic affections occurred a case of condyloma of the larynx, several of gummata and pharyngo-laryngeal stenoses. Amongst nervous affections (pareses, paralyses, spasm of the glottis, spastic cough, etc.) deserving of special notice was one case of hysterical aphonia, cured by hypnotism ; one of laryngeal paralysis in tabes dorsalis ; one of laryngeal paralysis, due to central cortical lesion ; many cases of undeveloped voice cured by vocal gymnastics. The neoplasms included three remarkable cases : one a papillary myxoma of the mouth in a small child ; one a sarcoma of the pharynx ; and an enormous naso-pharyngeal fibroma. Some cases of hæmatoma of the nasal septum, of œsophageal stenosis, and a case of foreign body in the air-passages, expelled after tracheotomy, are also recorded. **Massei.**

LUCAS, ROBERT (Dalkeith, N.B.).—**Case of Syphilitic Gumma situated in the Trachea successfully treated by Large Doses of Iodide of Potassium.** *British Medical Journal, December* 24, 1887.

RECORD of a case, with an undoubted history of syphilis, in which a large tumour occupied almost the entire lumen of the trachea below the vocal cords, and was apparently attached to its anterior wall. Soon afterwards cheesy degeneration commenced in the centre of the growth. *Mirabile dictu !* this tumour, which had been diagnosed to be of a tertiary syphilitic nature, yielded to the iodide of potassium in large doses !

Hunter Mackenzie.

LUC.—Notes on a case of Fœtid Tracheitis, in connection with Ozæna. *Soc. Méd. Pratique, December* 8, 1887.

A PATIENT was attacked with ozæna ; in spite of the irrigations of the nose the fœtidity of the breath remained, which did not coincide with the views of the author relative to the pathogeny of the unpleasant odour which characterises ozæna. Having observed that the breath was as fœtid in buccal as in nasal respiration, Dr. Luc thought of examining the larynx, which appeared normal, but having requested the patient to take deep inspirations he was enabled to see, in the interval between the vocal cords, the trachea literally covered with crusts of greenish yellow

mucus, showing the most complete analogy with the indications constantly found in the nasal fossæ of patients with ozæna. In the sputum of the patient were discovered, after colouring with aniline, besides isolated cocci and bacterii of different sizes, diplococci, corresponding to the description given by Lœwenberg of micro-organisms. which are, he believes, the active agents of the fermentation peculiar to ozæna. Luc has made bibliographical researches, and has found an analogous case of B. Fraenkel. **Joal.**

NECK, &c.

MUNK.—Researches on the Thyroid Gland. *Sitzungsberichte der Königlisch Preussichen, Akademie der Wissensch. zu Berlin*, 1887.

EXPERIMENTS on animals (dogs and monkeys) prove that neither the extirpation of the gland, nor the destruction of its tissues by ligature of all nerves and vessels, causes disturbance of any function, and it must therefore be admitted that the existence of the gland is not at all necessary for life or health, and that cachexia strumipriva is only to be looked upon as an unfortunate occurrence, and is not to be considered as a necessary consequence of extirpation. **Michael.**

HAHN (Berlin).—**A Method of Removing large portions of Goître without Tamponning, and without loss of Blood.** *Langenbeck's Archiv*, Bd. 36, Heft. 3.

ALL the arteries of the thyroid gland must be ligated. After incision of the capsule it is then possible to remove portions of the adenoid tissue as large as desired. It is not necessary to apply the spoon. Cutting-instruments can be used, and in this manner it is possible to avoid destruction of the remaining tissue. One case illustrates the method. **Michael.**

ZESAS (Berlin).—**Fifty Excisions of the Thyroid Gland. A Contribution to the Surgical Treatment of Goitres.** *Langenbeck's Archiv*, Bd. 36, Heft. 3.

REPORT of fifty cases, with remarks on cachexia strumipriva, and the methods of operation. The author recommends the method of Socin. **Michael.**

ZIEM.—Abscess of the Orbit and Fistula of the Lachrymal Sac from Suppuration of the Antrum of Highmore. *Allg. Med. Cent.*, 1887. *No.* 37.

THE combination of these three affections arose by continuity from the suppuration of the antrum. **Michael.**

OSBORN, S.—Staining of Skin from Nitrate of Silver.

REFERRING to recently published cases of this affection from painting the throat with nitrate of silver, the writer asks, How long is the period

necessary to produce thorough pigmentation of the whole body, and where does this pigmentation first manifest itself? From one-and-a-half to two years seems to be the period, and the parts exposed to the light, *e.g.*, hands and face, are those first affected. (See author's reference, *Medical and Chirurgical Transactions*, vol. ix., p. 231 *et seq.*, for the fullest information on this subject.) **Hunter Mackenzie.**

WALLER, AUGUSTUS D. (London).—**Pulmonary Paresis.** *British Medical Journal, December* 24, 1887.

A NOTE denying the existence of pulmonary vaso-motor nerves, and consequently showing the slender basis upon which Dr. B. W. Richardson's theory of pulmonary paresis rests. **Hunter Mackenzie.**

HUTCHINSON, JONATHAN (London).—**Harveian Lectures on Lupus.** *British Medical Journal, January* 7, 1888.

LUPUS is an insidious, slow disease, which begins in early life, and, although it preferably affects mucous membranes, has almost always its first development in the skin, more especially that of exposed parts. The characteristic by which it is recognized is the formation in the corium of a brownish-yellow, apple-jelly looking cell growth, usually preceded by a stage of congestion and inflammation. As a rule, at one period or other the affected tissue breaks down, and ulcers are formed. The lecturer discards the old terms applied to the disease, and prefers to speak of inflamed and non-inflamed lupus.

The general definition of lupus is, a "serpiginous, infective, scar-leaving inflammation of the skin and mucous membrane." It contains two great groups, Lupus vulgaris and Lupus erythematosus, which, though distinct, are yet closely allied by numerous connecting links.

From an analysis of fifty-six cases, the disease is shown in forty-one of these to have affected the face, and in the remaining fifteen the extremities. In the forty-one facial cases, the precise seat of the disease was as follows:—

Nose and cheeks	8
Cheek alone	9
Nose alone	15
Nose and lips	1
Chin	2
Face and limbs	4
Cheek and neck	1
Nose and foot	1

It is not common for the lupus patient to suffer from any other disease. Out of seventy cases collated by the lecturer, no fewer than fifty per cent. appeared, so far as could be ascertained, to be in good health, and to be connected with healthy families. Despite such statistics, however, the lecturer is inclined to the opinion that, in most instances, lupus is a scrofulous disease. If the mucous membranes suffer much, there is almost invariably a tuberculous family history. A proclivity to chilblains predisposes to certain forms of lupus. The lecturer has repeatedly witnessed that in persons of middle age who have suffered from lupus

there is a definite tendency for the scars to become attacked by cancer, and he has seen lupus and cancer existing in different regions, and independently, in the same person. A very important observation has been made by several, that in the skin the Malpighian layer is apt to grow downwards in processes much resembling those of epithelial carcinoma.

Reference is made to the tubercle-bacillus in its relation to lupus, and to the fact that many observers have found in the cell growth of common lupus a bacillus, which all agree in considering as identical with that of lupus. The opinion is meanwhile withheld as to the relation between this organism and the lupus process. The mucous membranes are perhaps seldom attacked, except in those who are tuberculous.

In regard to diagnosis, lupus ought not to be confounded with cancer; the latter does not produce cicatrization in the parts it has disorganized. A few rare forms of superficial rodent ulcer are the only conditions in which malignant action resembles lupus. In reference to syphilis, however, there is probably not a single variety of lupus which may not be closely simulated by syphilis. Syphilis may produce lupus inflammation. There may exist a "syphilitic lupus."

Regarding lupus of the mucous membranes, it is almost always in association with Lupus vulgaris that it is present. Usually, but not invariably, the skin is first attacked. The lecturer has several times seen it begin on the gums or the palate or in the cheek, without any like disease of the skin. It would frequently be impossible to identify it, were it not for the concomitant skin affection. The mucous membrane becomes thickened, papillary, and ulcerated, without the apple-jelly growth. The gums and soft palate may be destroyed, and the disease may extend to the larynx; it is here distinguished from syphilis by the bones being never involved, nor the palate perforated. It is a creeping, superficial process. How far the disease may extend down the throat is not known, nor whether it ever invades the stomach. Several of the lecturer's patients have, however, died of hæmatemesis.

Lupus of the nasal septum is merely a form of lupus of mucous membranes rendered peculiar by the part affected, and is frequently mistaken for syphilis. It usually commences just within the nostril, and a small ulcer forms, which soon perforates the (cartilaginous) septum. The edge of the ulcer may heal, leaving only a comparatively small hole, or it may extend to the vomer, but, as already stated, it never produces disease of the bone. These perforating lupus ulcers of the septum may occur without any skin lupus, but the proof that they are of the lupus nature is found in the frequency with which they occur with it. Perforating ulcers of the septum occurring as the sole lesion are by no means necessarily syphilitic, being often examples of lupus.

Hunter Mackenzie.

ASSOCIATION AND CONGRESS MEETINGS.

Ninth International Medical Congress.

SECTION OF LARYNGOLOGY.

The Pathology of Hay Fever. By DR. S. S. BISHOP (Chicago).

THE paper treated of hay fever as a neurosis affecting the upper respiratory tract, and proposed the name nervous catarrh as a substitute for the term hay fever. The latter is a misnomer, for the disease is not of necessity caused by hay, or accompanied by fever. Nervous catarrh is a name suggestive of both the pathology and symptomatology. The exciting causes are manifold, and attacks are generally unattended by fever; but the most conspicuous feature of the malady is its neurotic nature, and its most prominent symptoms are of a catarrhal character. The name proposed is applicable to certain functional derangements of the bronchial and intestinal mucous membranes also, and could be advantageously used, with properly modifying adjectives, to designate such disturbances. Illustrative cases were referred to in which sudden and copious diarrhœal discharges occurred just previous to the appearance of public speakers and musicians before audiences which they were to address or entertain. Immediately they entered upon their task the intestinal trouble vanished, and only returned again a few hours previously to their next appearance before the public. These paroxysms are as sudden in their attack and subsidence as veritable attacks of hay fever. Such seizures may be appropriately called intestinal nervous catarrh. Reasoning from analogy, we meet with no insurmountable difficulties in accounting for the phenomena of this disease on the neurotic theory. We have nervous dyspepsia occasioned by mental emotions. A certain combination of objective and subjective causes operating on one individual produces morbid manifestations referable to the bronchial mucous membrane, resulting in an attack of asthma—bronchial nervous catarrh. In another, the scene of this breaking of a nerve-storm is the nasal mucous membrane, eventuating in a paroxysm of hay fever—nasal nervous catarrh. All these are undoubtedly co-ordinate morbid conditions of the nervous system, finding expression in exaggerated and perverted functional activity.

Although the paper maintained that the malady was essentially due to an abnormal susceptibility of the nervous tissue, it did not claim that there was any organic lesion of the nerve-centres.

The arrangement of the nervous supply of the respiratory passages favours the existence of reflex nervous phenomena. One sympathetic nervous centre, the spheno-palatine ganglion, supplies branches to the lining membrane of the nose, pharynx, and Eustachian tubes. It has a motor, a sensory, and a sympathetic root. It communicates with the facial and pneumogastric nerves, thus uniting in the closest sympathetic connection the nose, throat, middle ears, larynx, and bronchi. Moreover,

the Schneiderian mucous membrane is continuous with the membrane lining all the passages named. Ablation of this ganglion sets up a severe catarrhal state of the Schneiderian membrane. A congestion once started in this structure may extend with unobstructed facility to the contiguous membranes, like the spreading of erysipelatous inflammation from one area of the skin to another. But the continuousness of these membranes does not satisfactorily account for all the symptoms produced in one part by impressions upon another. Certainly an inflammation in the throat may extend along the Eustachian tube to the tympanum, but there is no such reason to account for the sudden transitory tinnitus aurium which occurs in some persons immediately upon the ingestion of a draught of cold water or the inhalation of tobacco smoke, or for the cough occasioned by the contact of instruments with the external auditory meatus or with the inferior turbinated body or septum nasi, or for the paroxysms of sneezing produced by irritating the scalp. These intimate sympathetic relations between various portions of the animal economy exhibit themselves with exceptional force in patients of a pronounced nervous temperament. The theory that lesions situated in the nasal cavities may be responsible for the existence of common asthma has lately acquired a considerable following in America. But this is directly in the line of our reasoning, for it argues the reflex neurotic character of a disease which possesses close kinship to hay fever, not only in its etiology, symptomatology, and therapeutics, but in the morphology of its secretions. The manner in which exciting causes bring about attacks in hay fever is much the same as in the case of asthma.

There are three conditions upon which the existence of the disease depends—first, abnormally susceptible nerve-centres; secondly, hyperæsthesia of the peripheral termini of the sensory nerves; and thirdly, the presence of one of a large variety of irritating agents.

The hereditary character of the disease is an argument in support of the nerve theory. The histories of the families of the Rev. Henry Ward Beecher, Dr. Morrill Wyman, and Chief Justice Shaw were referred to as illustrating this point.

The nervous temperament predominates among this class of patients.

The periodicity of the malady favours the neurotic theory. Is it reasonable to assume that the pollen of various plants, which gives rise to attacks in different individuals, will be set free to float away on its fructifying pilgrimages on exactly the same day, and at nearly the same hour, in each recurring year, and that it will reach the nostrils of sufferers in their varying localities and situations and avocations simultaneously year after year? The variations which occur in the yearly advance of the seasons preclude this hypothesis.

The identity of the different forms of hay fever strengthens the nerve theory, while it weakens the pollen theory, for it shows that the disease exists under conditions that are least favourable to the operation of pollen; in fact, when the pollen argument is inadmissible—in the winter and spring. Pollen is an important exciting cause, but is only one among many.

Other arguments briefly mentioned were—the suddenness of the onset

and disappearance of attacks ; the most potent palliatives are nerve sedatives, tonics, and stimulants ; and the effect of mental emotions and physical exertion in preventing and arresting paroxysms.

The principal argument urged against the nerve theory is that many hay-fever sufferers have diseased nasal cavities. But we may say the same of that much larger proportion of our population who do not have hay fever. That we should find nasal hypertrophies, etc., concurrent with hay fever is not surprising in this catarrh-producing climate. Indeed, the diseased turbinated tissue may be a coincidence or a sequence rather than the cause of this malady ; for it is but natural to suppose that years of constantly recurring attacks of even a functional disturbance of the vaso-motor supply of these parts would result in a passive hyperæmia which would eventuate in proliferation of cells in the mucous and submucous tissues, and the growth of hypertrophies which might serve as a nidus for the reception and retention of irritating agents. But to argue that this condition is responsible for hay fever in infants, youths, and even in adults in whom there is no evidence of inflammatory changes before or between attacks, is not reasonable. The symptoms do not resemble those of an inflammation as much as they do an irregular and explosive discharge of a superfluity of nervous force. It has been claimed that destructive treatment of the sensitive areas in the nasal cavities would permanently cure hay fever, and many cases have been so treated by American physicians during the last three years. However, the most sanguine practitioners of this method have recently confessed disappointment at the results. Cases that were supposed to have been cured still suffer ; others are more or less benefited, while a few are worse for the operations. So far as I have been able to obtain definite data, they demonstrate that less than one-half the number treated are claimed to have been cured. This raises the point that it is not a simple inflammation with which we have to deal, for, if it were, local treatment should be attended with greater success. But granting that such treatment afforded immunity from further suffering, the nerve theory would not suffer in the least by the admission, for it assumes a pathological condition of the receptive end-organs of the nerves as well as of the perceptive nervous centres. Eliminate the susceptibility of either the central or peripheral nervous system, and you remove an essential element in the disease—destroy its entity. But what shall we say of that other large proportion of patients in whom suffering is caused not by irritation of the nasal membrane alone, but by irritation of the retina or the scalp, or by chilling of the skin, etc.? Shall we reason from analogy, be logical, and destroy the sensitive area—enucleate our patients' eyes, scalp or skin them? Yet if you follow the reasoning of the pollen school of theorists to its logical conclusion it will lead you to this *reductio ad absurdum*.

The neurotic theory is supported by the nature of the following causes :—Electric and gas light, over-exertion, anxiety, indigestion, dampness, chills, camphor, gases, feathers, perfumes, odours from animals, dry, hot, and impure air, various kinds of fruit, etc. Pollen and dust do not enter into the causative nature of these excitants.

Another corroborative fact is the excessive irritability and nervousness which patients experience just preceding and during attacks. The co-ordinate action of muscles is disturbed, and patients feel "jerky" and ill-tempered.

In studying this disease, the statements of those afflicted, relative to the history and phenomena of their complaint, should be accorded greater credence than is usually given the assertions of other classes of patients, inasmuch as they enjoy the distinction of being above the average in intelligence and culture. This is far from being an idle assertion, for it voices the experience of the best authorities on the subject, and is borne out by a reference to the list of membership of the United States Hay Fever Association.

Microscopists have recently demonstrated the presence of products called gravel in the nasal and bronchial secretions of hay fever and asthmatic subjects. It is supposed that this so-called gravel accumulates in the secretions of the respiratory passages, and acts as a local irritant in the same manner that a foreign body would.

Students of hay fever and asthma will appreciate the force and analogy in the following facts relating to neuroses of the skin:—Intense itching of the surface of the whole body may be produced by morbid alterations in the ovaries or uterus, anomalies of menstruation, diseases of the kidneys liver, etc. Neumann says: "There is no doubt that a large proportion of cutaneous diseases depend upon disorders of the vaso-motor nerves, which cause certain derangements of the circulation in the arteries, veins, and cutaneous glands. Anæmia and hyperæmia of the skin happen from vaso-motor irregularities, some from the brain, some from the spinal cord, or from the action of cold or the electric current, etc." Now, since it is admitted that there are both immediate and reflex functional nervous disorders of the skin, with what show of reason can it be denied that there are similar neurotic disturbances of that other skin which covers the interior surfaces of the body? The latter membrane is more vascular, more delicate, more sensitive, more highly organized than the skin. It possesses susceptibility to all agents which affect the skin, and to many others besides. For example, noxious gases, to which the skin is insensible, will irritate the mucous lining of the respiratory organs. The same laws which govern the action of the vaso-motor nerves of the skin also regulate the vaso-motor supply of the mucous membranes. If itching and burning of the skin are caused by morbid alterations in the ovaries, so is pruritus urethræ produced by disease of the bladder; pruritus nasi is generally accepted as a sign of worms in children; urticaria results from irritation of the gastric or intestinal mucous membrane; so may asthma arise in the same manner, or from an irritant applied to the post-nasal mucous surface; ear-cough is occasioned by contact of instruments with the skin of the external auditory meatus; and hay fever paroxysms result from irritation of the retina, the upper lip, or the scalp, or from chilling of the skin.

Finally, from a study of all the facts in our possession we are forced to the conclusion that the weight of testimony is in favour of the doctrine that hay fever is a reflex functional nervous disease. **S. S. Bishop.**

A Contribution to the Causes and Treatment of so-called Hay Fever, Nasal Asthma, and Allied Affections, considered from a Clinical Standpoint. By Dr. RICHARD HENRY THOMAS, Baltimore.

THE various factors that have been considered to enter into the causation of hay fever may be classified as follows, viz.—(1) The general nervous system; (2) Diseases of the upper air-passages, especially those that tend to nasal obstruction; (3) The existence in the upper air-passages of specially sensitive areas; (4) The existence of a peculiarity in the nerve-centres or nerve-endings, which renders them susceptible to the influence of certain excitants, which would be harmless to ordinary individuals.

(1) In regard to the general nervous system; while all admit that a neurasthenic or other morbid condition of the general nervous system is very often associated with, and often aggravates, hay fever, yet hay fever so frequently exists without it, and it is so frequently present without the paroxysmal phenomena, that it cannot be said to be an *essential* factor in the etiology of the complaint.

(2) The same may be said in regard to diseases of the upper air-passages. Any of them may exist with or without hay fever. As to the claim that the symptoms are largely due to nasal obstruction, we may urge against it that, in the greater proportion of cases of obstruction, these symptoms are not present, that even when asthma is present, occlusion is not the first symptom (the writer has seen typical cases of this kind where there was at no time any decided nasal obstruction), also, that reflex phenomena of nasal origin have been observed where the nasal tissues were atrophied, and that in hay fever patients it is generally possible to excite a temporary attack by irritating the sensitive areas, independently of the presence or not of nasal obstruction.

(3) In order to satisfy himself as to the claims put forward by many observers that there exist normally in the intra-nasal and naso-pharyngeal tissues certain sensitive areas which, if irritated, will give rise to the reflex phenomena of hay fever, etc., the writer instituted two series of observations. The first series was on those who suffered from some form of nasal or pharyngeal reflex neurosis, the second was on those who were entirely free from this, and whose upper air-passages were either healthy or affected with some simple catarrhal affection. As far as his observations have gone, Dr. Thomas's results are as follow, viz.:—*In the first series*, all were found to have some area or areas that was specially sensitive to the touch of the probe. But the location of these areas varied exceedingly so that almost every portion of the intra-nasal or pharyngeal tissues are noted as having been found to be specially sensitive. In some cases the sensitive area in one nostril would bear no relation to that in the other. In one case it was found in only one nostril. The reflex phenomena produced were, besides the usual lachrymation, violent paroxysmal sneezing, paroxysmal cough, temporary asthmatic dyspnœa, headache, etc. These observations were, of course, conducted between the attacks.

In the second series—that is, in those who were free from hay fever or any allied affection—it was generally impossible by the ordinary use of

the probe to produce any result beyond lachrymation. At times there would be slight sneezing and, though very seldom, a very slight expiratory effort. In some of these there was a high degree of ordinary hyperæsthesia. In this series no sensitive area could be found. In the former series there was a slight predominance in favour of the middle and posterior portions of the nares. The conclusion Dr. Thomas had reached from these observations was to adopt the opinion of those who maintain ; (1) *That, as a rule, there exists in the normal nose no special "reflex sensitive area," and that* (2) *when, under pathological conditions, such areas exist they may be found in any part of the upper passages.* This view is further verified by the instances we meet with when polypi and other morbid changes occur within the so-called areas of special sensation without any reflex disturbance resulting.

(4.) The writer thought that these considerations drove us to the conclusion that there exists some anatomical peculiarity in the nerve centres or endings, or both, that makes some individuals sensitive to certain irritants which are innocuous to ordinary individuals. Mr. Jonathan Hutchinson describes idiosyncrasy as "to a large extent a diathesis brought to a point." After every theory is exhausted, we have still to fall back upon individual peculiarity to explain why one set of irritants exercises an influence upon one person and another upon another. This underlying peculiarity existing, it will be greatly affected by the condition of the upper air-passages and by the condition of the general nervous system. It, however, occasions no disturbance until some exciting cause is present. The exciting cause may be found in inert substances floating in the air, in meteorological changes, or in the effects of sunlight and wind, in new growths or other morbid changes in the upper air-passages, in psychical impressions, or in irritation reflected from other parts of the body. At the best, none of these are ever anything more than *exciting* causes.

After giving in some detail illustrations of the action of most of these causes, the paper continued. Dr. Thomas had noted the influence of heredity, but had seen it in every station of life, not only in the Caucasian but also in the negro. The majority of his patients had been in the better class of life.

In the history of a paroxysm of hay fever, the hyperæmia and swelling are secondary phenomena, as truly as is the sneezing or the asthma, the primary cause being simply the excitation of the nerves, which are in a condition to respond to the irritant acting upon it.

In regard to treatment, the general health must be attended to, and remedies used especially addressed to the nervous system. The treatment, whether general or local, should be begun as soon as possible after the conclusion of the attack. If Mr. Hutchinson's definition of idiosyncrasy be correct, its presence should no more discourage treatment than the presence of a diathesis. The indications generally call for the use of the valerianates of zinc, iron, and quinine. Arsenic and hydrobromic acid are often useful. Locally, we must, of course, treat any co-existing affection or malformation. The special treatment consists in discovering and cauterizing, preferably with the galvano-cautery, all

sensitive areas in the upper air-passages, and, when necessary, destroying portions of the cavernous tissues. The indiscriminate destruction of this tissue is to be deprecated, as it is a normal one, and has an important physiological purpose to perform. The patient must be seen during the season of the next attack, after treatment has been carried out, in order that any remaining sensitive places may be cauterized. After four years' constant experience with the galvano-cautery, Dr. Thomas was more and more convinced of its general applicability and safety when properly used. To be successful the treatment must be thorough. Partial treatment does little, if any, good. **R. H. Thomas.**

On Intubation of the Larynx. By Dr. F. E. WAXHAM (Chicago).

THE author, while strongly advocating intubation, would not overlook the disadvantages and dangers of the operation. Among the most important mentioned were :

1st. The difficulty of performing it. There are comparatively few who possess the manual dexterity necessary for performing the operation quickly and well. Those who are not naturally dexterous, or who are not intimately acquainted with the anatomy of the parts, must practise faithfully on the cadaver, which is not always convenient or possible.

2nd. The danger of injuring the soft tissues or of perforating the trachea from the lack of skill in performing the operation.

3rd. The difficulty of extracting the tube, especially where the head rests low down in the larynx.

4th. The danger of peeling up of membrane below the tube, thus occluding it.

5th. The danger of pushing membrane down ahead of the tube upon its introduction.

6th. The difficulty of swallowing.

These dangers were not so serious but what they could be overcome. The 1st, 2nd, and 3rd, by repeated trials upon the cadaver, and by accepting every opportunity of making a digital examination of the larynx of the healthy child. The 4th and 5th difficulties will be obviated by the immediate removal of the tube, when, if the membrane is not rejected, the trachea-forceps, devised for that purpose, may be introduced and the membrane removed, or tracheotomy performed.

The 6th danger will be overcome by exercising the greatest judgment in the selection of the tube and in the feeding of the patient. If too large a tube is used it will ride high in the larynx, and will cause so much irritation from the pressure that the patient will swallow with great difficulty. Always select too small a tube rather than too large a one. By giving cracked ice, ice-cream, and semi-solids all together the difficulty will be greatly lessened. The employment of a tube with artificial epiglottis is also of great assistance in swallowing.

The advantages over tracheotomy were then referred to.

1st. It can be performed by the expert quickly, almost instantly

2nd. There is no loss of blood to further prostrate the patient.

3rd. There is no injury to the soft tissues, and little or no pain.

4th. There is no shock from the operation.

5th. There is no danger from septicæmia or from erysipelas as from an open wound.

6th. There is very little irritation from the tube, much less than from a tracheotomy tube.

7th. There is no open wound to close by slow granulation.

8th. The air enters the lungs through the natural passages.

9th. Recovery is rapid after the removal of the tube.

10th. We can do with less skilled attention than after tracheotomy.

11th. Consent of parents is much more easily obtained.

12th. We can save as large a proportion of cases as by tracheotomy at all ages, and a much larger proportion among children less than three years of age.

In proof of the latter assertion, the author reported 1,007 cases with 266 recoveries, or 26·54 per cent.

In 661 cases the ages were recorded, and were as follow:

Patients.	Age.	Recoveries.	Per cent.
31	under 1 year.	5	16·12
97	,, 1 ,,	15	15·46
149	,, 2 years.	29	19·46
140	,, 3 ,,	42	30·00
98	,, 4 ,,	32	32·65
56	,, 5 ,,	19	33·92
27	,, 6 ,,	10	37·03
32	,, 7 ,,	16	50·00
12	,, 8 ,,	5	41·66
10	,, 9 ,,	5	50·00
2	,, 10 ,,	1	50·00
5	,, 11 ,,	2	40·00
2	,, 14 ,,	0	00·00
Total 661		181	27·38

Average age, three years and three months.

There were 277 patients under three years, with 49 recoveries, or 17·68 per cent.

There were 384 patients over three years, with 132 recoveries, or 34·37 per cent.[1]

F. E. Waxham.

Surgical Section.

Richardson, Maurice H. (Harvard).—*The Possibility of Operations on the Œsophagus through the Stomach, as shown by Dissections.*

The text of this paper is the case of a man, aged thirty-seven, tall and strong, who, while eating, had swallowed a denture of four teeth. On examination next day, the teeth were found lodged near the cardiac end of the œsophagus. Numerous attempts were made to dislodge them, and it was thought that at last the foreign body had passed into the stomach.

Eleven months after the accident the man returned, and the foreign body was found in its old place—fourteen inches from the upper incisors.

[1] Since making the above report the writer has had eight cases, all diphtheritic, with four recoveries. The ages of those recovering were six years, four years, twenty-two months, and nine years respectively.

Continual pain was present, and liquid food could only be taken with difficulty. The author considered that two methods of procedure were possible—œsophagotomy and gastrostomy. He selected the latter because it had been shown that the plate was very firmly impacted, and it was very probable it would be necessary to use the fingers in dislodging it. An incision was made, parallel to the lower margin of the left lower ribs, six inches in length, through which the stomach was drawn and held upon aseptic towels by assistants. A small opening was then made midway between the curvatures, and forceps introduced, but the cardiac opening could not be felt. The foreign body was detected by the fingers about two inches above the diaphragm, and was removed after careful manipulation by the middle and index fingers. The patient made a good recovery, though complicated by slight lung symptoms, caused probably by the breaking of a small peri-œsophageal abscess into the lung by the manipulation of the fingers.

The author subsequently made an elaborate series of experimental observations on the cadaver with the object to determine certain points in connection with the impaction of foreign bodies in the gullet. In reference to measurements, he found that when the head is thrown back, in the position for passing the probang, the distance from the upper incisors to the opening in the diaphragm is not constant. The average distance is fourteen and a half inches. There is no constant ratio between the height of the individual and this measurement. One subject, six feet in height, gave fourteen and a half inches ; another, with a height of four feet ten inches, measured fifteen and a half inches. The greatest distance was seventeen inches, the least ten and a quarter inches. The average distance from the cricoid cartilage to the diaphragmatic opening was seven and a half inches. As a rule, therefore, it may be affirmed that, if the probang is arrested at a point more than thirteen inches from the incisors, the point of obstruction is probably at or near the cardiac end of the œsophagus. Another point determined by the author's experiments is that, through the media of an external œsophagotomy and a gastrostomy, it is possible to explore the whole of the œsophagus by introducing the fingers of different hands into these openings, and causing them to meet in the gullet. He affirms that in the living subject there is no point in the œsophagus which cannot be reached by the finger, either from above or below.

The general conclusion at which the author has arrived is : if the foreign body be situated not less than thirteen inches from the upper incisors, or six from the cricoid, the operation of gastrostomy ought to be performed ; if the distances be less than these, the body is best reached from above.

The paper concludes with some practical remarks on the method of opening the stomach. It is worthy of careful study.

[The writer's experiments regarding the length of the gullet do not quite harmonize with the observation of Sir Morell Mackenzie, who states that "the length of the œsophagus varies according to the stature of the individual" ("Diseases of the Throat and Nose," vol. ii., p. 2). This apparent discrepancy may, however, be explained by the gullet,

as referred to by Mackenzie, commencing at the lower border of the cricoid cartilage, and thus wanting that part of the cervical portion, where, probably, individual differences are largely manifested. Mackenzie's measurements from the cricoid cartilage to the lower end of the gullet, in the adult male, are about two inches in excess of the average distance of the author.]

REPORTS OF SOCIETIES.

British Medical Association: South Eastern Branch—East Sussex District.

December 8, 1887.

LAMMIMAU, —.—*Swelling of Face.*

A GIRL was shown, who had suffered from repeated attacks of erysipelas thirteen years previously, and had now marked swelling of the face, especially about the eyes. The thyroid gland was very small, but not entirely absent. The affection had certain superficial resemblances to myxœdema, and was attributed to some affection of the absorbents. The exhibitor had seen other similar cases.

Hunter Mackenzie.

British Medical Association: Metropolitan Counties Branch—South London District.

December 19, 1887.

SYMONDS, CHARTERS J.—(1) *Removal of Portions of the Tongue; cases shown, but no particulars given;* (2) *Methods of Removal of the Tongue for Epithelioma, and the Indications for Operative Treatment.*

PAPER read, followed by discussion, neither of which is reported.

Hunter Mackenzie.

British Medical Association: New South Wales Branch.

October 7, 1887.

SKIRVING, R. SCOT. — *Tracheotomy.*

AN adjourned discussion on a paper read by Dr. Skirving (see *Journal of Laryngology and Rhinology*, vol. ii., p. 91), which elicited nothing new.

Hunter Mackenzie.

British Medical Association: Birmingham and Midland Counties Branch.

October 28, 1887.

SAUNDBY, ROBERT (Birmingham).—*Innominate Aneurysm.*

EXHIBITION of specimen, the size of a turkey's egg, which had caused death by pressure on the trachea. During life there was a pulsating tumour above the sternum, and dulness over the manubrium and on each side, but no *bruit* could be heard.

Hunter Mackenzie.

Medico-Physical Society of Wurzburg.

Meeting, January 7, 1888.

DECKER and SEIFFERT.—*On Mycosis Leptothrica Pharyngis (with demonstration)*

DECKER gave a report upon thirty-four published cases. White excrescences occur on the tonsil and the lingual glands. They cause no re-active inflammation and are very obstinate against treatment. The galvano-cautery is the best cure.

The microscope shows that the excrescences consist of epithelial detritus and leptothrix.

SEIFFERT showed two patients who had been affected with this disease, and were cured by the galvano-cautery. He also spoke of the biology of leptothrix.

Meeting, January 21, 1888.

SEIFFERT and HOFFA.—*On Congenital Stenosis of the Larynx and External Laryngotomy (with demonstration of the patient).*

A LADY, seventeen years old, was born with cyanosis and difficulty of breathing, which diminished latterly. She could never speak above a whisper. The laryngoscope showed a junction of two-thirds of the vocal bands. After having tried intra-laryngeal treatment without any effect, Dr. Hoffa performed tracheotomy and laryngotomy. It could then be seen that the under part of the larynx was filled with connective tissue. The neoplastic tissue was removed with forceps and scissors, and the wound sewn up. The result has been excellent. Respiration is free, and the patient speaks with a loud normal voice. Dr. Seiffert spoke of the etiology and pathology of stenoses, Dr. Hoffa of laryngotomy with regard to carcinomata. **Michael.**

Hamburg Society of Physicians.

Meeting, December 24, 1888.

KÜMMEL demonstrated two cases of extirpation of the thyroid gland, and one case of suppuration of the thyroid gland, originating during abdominal typhus, and cured by incision and partial extirpation of the gland.

FRÄNKEL demonstrated a stomach affected with diphtheria, following upon tonsillar diphtheria. **Michael.**

General Congress of Physicians at Cologne.

Meeting, January 20, 1888.

HOPMAN.—*On Warty Growths of the Mucous Membrane of the Respiratory Organs.*

THESE growths differ from the fibromata by their cauliflower-like appearance. There are hard and soft warts. They are all benign. They are especially found on those parts of the mucous membrane which are exposed to mechanical injury, such as the conchæ, the velum, and the vocal bands. The greater number of laryngeal growths are papillomata. He never saw a transformation of papilloma into a malignant growth. **Michael.**

Society of Physicians in Vienna.

Meeting, November 25, 1887.

ZEMAN showed a specimen of sarcoma of the trachea. The patient died a day after he came into the hospital for bronchoblennorrhœa. Sarcomata of the trachea are very rare.

SCHRÖTTER related the clinical details of the case. He saw the patient first in 1867. The tumour filled the whole trachea. After anæsthetizing with chloroform-morphia, he could remove two-thirds of the tumour with a proper instrument. The last portion was destroyed by injection of ferrum sesquichloratum. Two years later there was recurrence and repetition of the same operation. A third time he saw the patient, in 1879. Schrötter mentioned also a second case of sarcoma, which was also cured by a young physician by injection of iron, but the girl died of suffocation.

CHIARI also related a case of sarcoma of the trachea situated on the third ring. **Michael.**

Meeting, December 2, 1887.

HOFMOKL exhibited a child in whom he had successfully performed laryngo-tracheotomy for removal of a foreign body (piece of bone).

HOCHENEGG had also performed laryngo-tracheotomy to remove a coin from the larynx.

RUD exhibited a boy in whom he had performed œsophagotomy for a stricture; he then introduced through the wound a probe into the mouth, and larger probes fixed on the smaller probe. The boy was cured.

WEINLECHNER related that he had often performed this method.

ROHE showed an electric laryngoscope. **Michael.**

Medical Congress in Munich.

Meeting, January 11, 1888.

RUDINGER.—*On the Influence of the Thyroid Gland on the Nourishment of the Brain.*

THE consequences of the extirpation of this gland in men and animals, as cachexia strumipriva, the diminution of mental capacity, myxœdema and so-called cretinism, prove that the gland has a great relation to the nourishment of the central nervous system. Under nervous influences, the circumference of the gland may differ in a high degree; it can retain a large amount of blood, and be therefore a regulating reservoir for the blood-supply of the brain, through the dilatation and destruction of its four great arteries.

GRASHEY related that Maas, a surgeon of great experience, never saw cachexia strumipriva. Moreover, if small portions of the gland are left, no observer saw cachexia, and this, too, is not observed in cases of pathological degeneration of the gland. It is very possible that the cachexia is the consequence of the destruction of the lymph-system of the gland.

RUDINGER.—The regulatory influence of the thyroid gland is not a purely mechanical one, but is affected by the vaso-motor and vaso-dilator nerves of the gland. The larger lymph-vessels of the brain do not pass the thyroid gland, and in this relation extirpation cannot be of great influence.

ANGERER.—Vaso-motor influence cannot be the cause of the cachexia, since ligature of the vessels of the gland as introduced by Wölfler is not followed by cachexia; only extirpation has this effect. The gland is a rudimentary organ. It can only be possible that the cachexia is caused by failure of its secretion. The organ is not equal to the spleen.

BOLLINGER.—Cachexia is not easy to declare; a regulatory function of the gland is not probable. The ligature of the carotid is in a short time corrected by collateral circulation. Myxœdema is also found in persons with normal thyroid glands.

ZIEMSSEN related a case of sarcomatous degeneration of the gland without cachexia.

WINCKEL remarked that the gland is often enlarged during gravidity.

Michael.

Berlin Medical Society.

Meeting, January 25, 1888.

Prof. VIRCHOW showed a specimen of laryngeal phthisis cured. **Michael.**

Cambridge Medical Society.

November 4, 1887.

RANSOM.—*Some Cases of Diphtheria.*

NOTES of six cases, in all of which albumen and paralytic symptoms were present. One died, a girl of fourteen, who succumbed suddenly on the eighteenth

day, apparently from syncope. The cases were all treated with liq. ferri perchlor. fort. in hourly doses, and hourly painting of the throat with a weak, watery solution of glycerine of tannin. A discussion ensued, but is not reported.

FRANCIS.—*Œsophageal Diverticula.*

THE author classifies these thus :—(1) Congenital ; (2) Diverticula depending on stricture of the tube below ; (3) Pressure diverticula, usually occurring near the junction of the œsophagus and pharynx ; (4) Traction diverticula, usually occurring near the tracheal bifurcation. The different methods of production of these diverticula were referred to, and a specimen was shown from a phthisical subject, in which a large abscess-cavity at the bifurcation of the trachea communicated with the œsophagus and simulated a true traction-diverticulum.

Hunter Mackenzie.

Royal Academy of Medicine in Ireland: Medical Section.

November 18, 1887.

WRIGHT, W. M. A.—*Lymphadenoma.*

A GIRL, aged twelve and a half years, previously quite well, commenced to suffer from enlargement of the cervical glands, with cough and the general appearance of illness. Soon diarrhœa with pyrexia set in. She was very anæmic, with a bright malar flush ; the anterior cervical glands were very much enlarged, nodular, and hard ; the posterior cervical, axillary, and inguinal glands were also enlarged. Shortly afterwards pigmentary staining was visible on the sides of the neck, and on other parts of the body ; this gradually developed. No remedy had been found of service, although arsenic had been twice given until marked constitutional symptoms ensued.

Dr. GRAVES said he had seen this case, and the glands, though hard, had a feeling of elasticity as distinguished from the dull feeling of the ordinary strumous glands. The tonsils were slightly enlarged.

Dr. A. W. FOOT remarked that it was unusual to find ordinary lymphadenoma pyrexial, unless complicated with tubercular disease. He asked whether a distinction could be made with the fingers between the glands. In benign cases this separation was perceptible, but in lympho-sarcoma, which was really malignant, the glands were fused together, and could not be separated.

Drs. NIXON and FINNY regarded the bronzing of the skin as a feature of great interest.

Dr. WALTER SMITH stated that the only way to distinguish clinically between leucoctyhæmia and lymphadenoma was by a microscopical examination of the blood.

In reply, Dr. WRIGHT stated that the upper glands of the neck from ear to ear were not separable, though they felt as if they could be easily isolated ; on deeper pressure they were fused together. In the lower part they were perfectly distinct.

Hunter Mackenzie.

Sheffield Medico-Chirurgical Society.

November 24, 1887.

JEFFREYS, —(Chesterfield).—*Foreign Body in Bronchus.*

A BONE became impacted in the right bronchus of a man aged sixty-two, and was expelled during a fit of coughing. The author remarked on the value of hyoscyamine, and attributed much to its influence in the present case. (As to how this influence was manifested, no information is given.) **Hunter Mackenzie.**

Brighton and Sussex Medico-Chirurgical Society.

December 1, 1887.

MACKEY, —.—*Lupus treated by Resorcin.*

TWO cases were shown healed after a few weeks' treatment by an ointment of resorcin (20 per cent.) after previous scarification. The first case was a girl of nineteen; the disease was of a strumous, indolent nature, affecting cheek and chin. The second case was a woman aged fifty-four, with face, nose, and lip deeply affected. The application of resorcin was attended with comparatively little pain.

WHITTLE, —.—*Recovery from Lymphadenoma.*

REPORT of a case of spontaneous recovery. **Hunter Mackenzie.**

Nottingham Medico-Chirurgical Society.

December 2, 1887.

ANDERSON, —.—*The Treatment of Arterial Hæmorrhage from Wounds in the Neighbourhood of the Tonsil.*

THIS consists in tying the wounded artery at its bleeding point by means of an incision through the cheek and ramus of the lower jaw. **Hunter Mackenzie.**

Midland Medical Society.

December 2, 1887.

HAWKES, —.—*Foreign Body in Bronchus.*

A BOY, aged one year and eleven months, choked whilst eating a portion of rabbit. A piece of bone was dislodged from the back of the mouth, and the asphyxia ceased, leaving a short cough. He was taken to the Children's Hospital, and tracheotomy was performed (why?) with a fatal result. At the autopsy a vertebra of a rabbit was found in the bronchus leading into the upper part of the left lung. The lung itself was much collapsed, and in a condition of croupous pneumonia.

MARSH, —.—*Resection of a Portion of the Thyroid.*

A BOY, aged fifteen, was shown on whom this operation had been performed for simple bronchocele, causing pressure symptoms. A median incision was made, and a piece the size of an orange was removed, with immediate relief. The remaining parts of the lateral lobes took on an atrophic process.

LLOYD, JORDAN.—*Papilloma of Larynx.*

SPECIMEN shown. It grew from the lower edge of the left vocal cord, and, after failure to remove it with forceps, was rubbed off by means of a piece of dry sponge attached to the end of a laryngeal probe.

CLAY, AUGUSTUS.—*Tumour (Fibroma) of Superior Maxilla.*

SPECIMEN shown. **Hunter Mackenzie.**

Leeds and West Riding Medico-Chirurgical Society.

December 2, 1887.

JACOB, ERNEST (Leeds).—*Treatment of Laryngeal Phthisis.*

THIS paper, and the discussion that ensued, elicited nothing new.

CAMERON, SPOTTISWOODE (Huddersfield). — *Relations of Meteorology and Respiratory Death-rates in Huddersfield.*

THE author showed—(1) That the phthisis curve, and that from other lung

diseases, closely corresponded ; (2) That the moisture curve generally corresponded with the disease curves ; (3) In the single year, where a diminution of moisture corresponded with an increased respiratory death-rate, the effect of the former had been overborne by a decrease in the diathermancy of the atmosphere ; (4) That the coldness of the winter, as a rule, directly increased the mortality, though less regularly than did an increase in the atmospheric moisture.

ALLAN,—.—*Malignant Disease of Larynx.*
EXHIBITION of specimen. **Hunter Mackenzie.**

Pathological Society of London.

December 6, 1887.

HEBB, —.—*Bacilli in Diphtheria.*—Card specimen.

EVE, —.—*Ranula, Illustrating Origin from Kuhn's Glands.*—Card specimen.
Hunter Mackenzie.

Northumberland and Durham Medical Society.

December 8, 1887.

MURPHY, —.—*Leucoplasia of Tongue.*
EXHIBITION of a man who was improving under arsenic and iodide of potassium.

PAGE, FREDERICK (Newcastle-on-Tyne).—*Stretching of Spinal Accessory Nerve for Torticollis, due to Injury.*
EXHIBITION of case. Mr. Croft thought the result good, and mostly due to the fact that the disease had been caused by injury, and not by central lesion.

ROBERTSON, WILLIAM (Newcastle-on-Tyne).—*The Galvano-Cautery in the Treatment of Diseases of the Throat and Nose.*
PAPER held as read.

LEMONT — (Newcastle-on-Tyne).—*Adenoid Diseases of the Pharynx.*
PAPER held as read. **Hunter Mackenzie.**

Clinical Society of London.

December 9, 1887.

BARLOW, THOMAS (London),—*Acute Enlargement of the Thyroid in a Child.*
A BOY, aged three years, was just recovering from a slight attack of erythema nodosum. He had been taken out of doors, and the day after he suffered from nasal catarrh, with pain in the neck, and slight enlargement of the thyroid, especially the left lobe. This increased, caused much pain and dysphagia, was accompanied by fever (103°), and lasted for about a fortnight, with a more acute period of four days' duration. Great relief followed the application of a leech to the centre of the swelling. The author gives a summary of the literature of the subject, and concludes that, as the enlargement succeeded upon erythema nodosum, it might be considered by some as of rheumatic origin, though no other rheumatic phenomena were observed, and its severity was greater than that of recorded rheumatic cases, the acute duration of which was not longer than forty-eight hours. The author himself is inclined to place the present case in Lucke's idiopathic group, and to accentuate its association with slight nasal catarrh, and sequence on exposure to cold when in an anæmic condition.

Dr. STEPHEN MACKENZIE mentioned the case of a gentleman who died from sudden inflammation of the thyroid, and pressure of the gland upon the trachea. Cases of acute enlargement of the thyroid often ran a very rapid course.

Mr. BERRY referred to several fatal cases of acute enlargement of the thyroid, which usually occurred at or about the period of puberty.

Dr. ANGEL MONEY mentioned a case of characteristic rheumatic thyroiditis occurring in a young lady; the swelling had the clinical course and characteristics of rheumatic swelling of a joint, but did not in any way resemble a goître.

Dr. BARLOW, in reply, thought the distinction between those cases and goîtres was very marked. Practitioners should note the condition of the thyroid in cases of rheumatic fever. **Hunter Mackenzie.**

Medical Society of London.

December 12, 1887 (*vide* also "Brit. Med. Journal," December 17, 1887, p. 1347).

RICHARDSON, B. W. (London).—*Acute Pulmonary Paresis.*

THE writer, under the new term of pneumoparesis, defined "an acute form of disease usually confounded with pneumonia, in which the symptoms are due to sudden failure of nervous stimulus to the vascular pulmonary systems, nutritive and respiratory." He narrated three cases, in women, which all terminated fatally in a few days by asphyxia, pure and simple. The discussion which ensued is of more interest to the physician than to the laryngologist. **Hunter Mackenzie.**

REVIEWS.

GERDTS, A. E. (Spracharzt).—**The Causes of Stuttering and the Natural Cure.** *Bingen am Rhine*, 1887, 15 pages.

THE author regards stuttering as caused by faulty respiration combined with the consciousness of stuttering on the part of the individual. It must be cured by learning to respire correctly and to use the inspired air properly. By following this method, the author has cured 752 cases in seventeen years.

BRESGEN, M. — Krankenbuch fur Rhino-laryngologen mit 8 Luxienbildern zum Enzeichnen der oertlichen Befunde. *Kommissionsverlag von Joh. Alt, in Frankfurt am Rhein.* Price, 100 Bogen M. 6 (6s.); 500 Bogen M. 25 (£1 5s.)

DR. BRESGEN has given here a practical scheme for laryngologists. Each page is destined for one case. There are given special signs of every medical examination (simple visits, tonsillotomy, galvano-cautery, &c.). On every page is a schematic design of the nose, the larynx, the mouth and the retro-pharynx, in order that the pathological specialities of the case may be recorded. These sheets much simplify the practical and scientific recording of cases.

HERYNG (San Remo).—**The Curability of Laryngeal Phthisis.** *Stuttgart*, 1887. *With three wood-cuts and three lithographic plates.* 190 *pages.*

LATTERLY Heryng and Krause have espoused very active and surgical treatment of laryngeal phthisis. Krause was the first to cauterise the ulcers with lactic acid, and Heryng, who is well satisfied with the results of this method, believes the method can be improved upon by destroying the walls of the ulcers with the sharp spoon. He unites the different communications which he has made into a book, and adds a very

interesting essay on the whole question. The first part of his book deals with the etiology and pathological anatomy of laryngeal phthisis; dealing with the question of primary laryngeal phthisis, which is so important in reference to its curability, he relates a case of artificial laryngeal ulceration from injection of tubercle bacilli into the jugular vein of a rabbit, and speaks of the entrance of tubercular bacilli into the epithelium of the mucous ducts, the relation of laryngeal catarrh to laryngeal phthisis, of catarrhal ulcers, of laryngitis chronica desquamativa (pachydermia diffusa of Virchow) and its relation to erosive ulcers. He also insists that circumscribed affections of the posterior laryngeal wall are in the highest degree suspicious of laryngeal phthisis. He adds a chapter on the histological and anatomical proofs of the curability of laryngeal phthisis. He says with great truth that we must prove the possibility of the spontaneous curability of a disease if we are to urge a cure by our medications. The second part of the book treats of the different cures of laryngeal phthisis. He relates and criticizes the method just now used for this purpose, with special relation to the treatment with lactic acid recommended by Krause and himself. He gives a great many observations on the influence of this medicament, which prove its efficacy. In eleven cases he has observed a cure after this treatment during six months to two years and six months. He then speaks of the surgical treatment of the disease, firstly of the incisions of Moritz Schmidt, and then on his own method of curettement of the larynx with subsequent lactic acid treatment. He describes his new spoons—four different instruments which can be fixed on one handle and can also be fixed in every position. The larynx must be anæsthetised in a complete manner with cocaine, and then all pathological products must be removed by scraping movements of the instrument. He details twelve cases in which cicatrization resulted, in nine within three to sixteen months. Then follows a description of the method of submucous injections of lactic acid, which did not give to the author such good results as are described by Dr Major (Montreal). A short report on the effect of treatment with iodoform emulsions follows. The author concludes with the results of the surgical treatment (sixteen cases, with twelve cures, three improvements, one negative), and adds remarks upon the general treatment of laryngeal phthisis. The contents of the book can only be indicated shortly here, but it may be said that it will be necessary for every laryngologist to read it. Those also who do not share the enthusiasm of the author for such an energetic treatment of the disease, will find in it a very well written and interesting monograph on laryngeal phthisis.

NOTE.

Dr. Solomon Solis-Cohen, of Philadelphia, a Fellow of the American Laryngological Association, has been elected Professor of Clinical Medicine and Applied Therapeutics in the Philadelphia Polyclinic; and has also been appointed Lecturer on Special Therapeutics at Jefferson Medical College.

London: Paraon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Article, p. 187.—Hahn's Operations of Resection of the Larynx.

New Instruments and Therapeutics, p. 191.—MACKENZIE: Nasal Saw. BRESGEN: New Instruments. SCHECH: Laryngophantom. ROE: Electric Saw. MAJOR: Adenomatome. WHITE: Cocaine in Croup. PITTS: Poisoning by Cocaine. VRUNNELA: Cocaine in Throat and Nose Diseases. DODGE: Anti-pyrine in Asthma. JENNINGS' Anti-pyrine as an Anodyne. MACDONALD: Sugar and Tea. HEYMANN: The Climate of Egypt. SIMPSON: The Treatment of Whooping Cough. JEFFRIES: Anti-bacterial Action of Iodoform. GENOIS: Deodorised Iodoform.

Diphtheria, p. 194.—CHEATHAM and OUCHTERLONY: Identity and Non-identity of Pseudocroup and Diphtheria. MINNICH: Ibid. LUDWIG: On Diphtheria. CAILLE: A Method of Prophylaxis. FERGUSON: Clinical Study. MALLOCH: Tracheotomy in Diphtheria. GUTH: Statistics of the Lazarenkrankenhaus. WESENER: Two Cases. WACHSMUTH: Diphtheria, Scarlatina, and Morbilli. HOFFMANN: The Loeffler Bacillus. HEYGATE: Diphtheria during Pregnancy. VILATO: Diphtheritic Paralysis. MACDONNELL: Knee-jerk in Diphtheria. HOLT: Multiple Neuritis. LE GENDRE: Antiseptic Treatment of Diphtheria. HOGEBOOM: Bicarbonate of Soda in Croup.

Nose and Naso-Pharynx, p. 200.—GOODWILLIE: Nasal Intubation. MAJOR: Chronic Nasal Catarrh. IBID: Foreign Body in Nose. WYATT: Mucous Polypi. KAYSER: Upper Respiratory Tracts in Respiration. KONIG: Operation for Retronasal Polypi. WALLE: Clinical Remarks. FREUDENTHAL: Hernias and Nasal Obstruction. MCDONAGH: Rhinoscleroma. PRINGLE; A Curious Accident.

Mouth, Tonsils, Pharynx, &c., p. 203. — BARKER: Operation for Epithelioma. PADLEY: Treatment of Cancer. BARWELL: Excision of the Tongue. BROSIN: Black Tongue. BEISSEL: Syphilitic and Mercurial Ulcers of the Tongue. PETERSEN: Extra-genital Syphilitic Infection. ENGEL: Prophylaxis. LUCAS: Epithelioma of the Lip, &c. ROBERTSON: The Lingual Tonsil. DUNCAN: Adhesion of Palate to Pharynx. BLAIRS: Hæmorrhage after Tonsillotomy. LENNOX BROWNE: An Unrecognized Cause of some Throat Ailments. WAY: Suffocation from Phlegmonous Tonsillitis. PETEZYNSKI: Acute Pharyngitis. OLTUSZEWSKI: Mycosis Leptothricia. SOTA: Œsophagotomy. STROEM: Foreign Body. Œsophagotomy. OPITZ: Blind Ending of the Œsophagus.

Larynx, p 208.—PALMER: Intubation. ATHERTON: Fracture. SCHWEIG: Causes of Vocal Disturbance. MAJOR: Cases. SREBRNY: Tuberculosis. MAJOR: Arytenoid Disease. IBID: Cases. STOERK: Cause of Shock after Extirpation. LEWIN; Perichondritis. BOSLEY: Laryngeal Stenosis. POLLAK: Laryngeal Syphilis. SOKOLOWSKI: Laryngeal Polypi. MCDONAGH: Primary Tuberculosis. INGALS: Rheumatic Laryngitis. MAJOR: Nutshell in Larynx. PIENIONZCK: Pin in Bronchus. JURIST: Sarcoma of Larynx. SOLIS COHEN: Treatment of Intra Laryngeal Abscess. BARTHOLOW: Respiratory Neuroses. ROSEN: After-treatment of Tracheotomy. LOW and KINTZING: Spasmodic Asthma. BELL: Wound of Internal Jugular Vein. KURZ: Reflex Cough. HAJIK: Tubercular and Carcinomatous Perichondritis.

Neck, &c., p. 216.—TAYLOR: Exophthalmic Goitre. LLOYD: Ibid. WOLFENDEN: Ibid. ROTH: Carcinoma of Thyroid. SHELSWELL: Myxœdema. WATT: Ibid. FRASER; Dyspnœa of Bronchitis. GROSS: Carcinoma of the Breast.

Societies, p. 218.—Edinburgh, Hamburg, Berlin, Riga, Erlangen, Stockholm, Toronto.

Reviews, p. 221.—GOTTSTEIN: Diseases of the Larynx. BULLAR, M. and J. F., Recipes for Fluid Foods.

Notes, p. 222.

THE BEST PEPSIN

Pepsin in Scales (Fairchild).—This is absolutely free from Starch, Milk, Sugar, Acids, Artificial Peptone, or any extraneous substance whatever. One grain of Pepsin (Fairchild) in *Scales* or *Powder* will digest 1,000 grains of albumen. By experience and constant experiment we have steadily refined and improved this product, and now present the peptic ferment in a state of marvellous activity, isolated from all reagents or impurities, and of demonstrated uniformity. We do not attempt to secure profit or cheapness of product by treating the entire stomach, and thus obtaining the admixture of a peptone or any albuminoid that is separable from the peptic ferment.

Pepsin (Fairchild) is supplied in the form of *scales for making solutions* and general manufacturing purposes, in the form of *powder for dispensing*, and in *Tabloids* (1 gr. each) *for easy administration to fastidious patients.* The Fairchild Pepsin is rapidly superseding the ordinary pepsins, many of which are utterly worthless. Fairchild's Pepsin is no more expensive than most of the common pepsins, though it possesses many times the strength and activity.

REDUCED PRICES:

		Retail. Each.	Price to the Profession. Per doz.
Fairchild Pepsin in Scales	¼-oz bottles	2/0	20/0
,, ,, ,, ...	1-oz. ,, ...	6/0	60/0
,, Pepsin Powdered	¼-oz. ,, ...	2/0	20/0
,, ,, ,, ...	1-oz. ,, ...	6/0	60/0
,, Pepsin Tabloids (1 gr.) ...	25 in bottle	1/6	14/0
,, ,, ,, ...	100 ,, ...	4/6	42/0

BURROUGHS, WELLCOME, & CO., Snow Hill Buildings, LONDON, E.C.

SUPPLIED BY ALL CHEMISTS.

THE

JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. MAY, 1888. NO. 5.

The Editors invite original contributions.

Fifty Reprints will be supplied to each author gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

HAHN'S OPERATIONS OF RESECTION OF THE LARYNX.

AT the Congress recently held in Berlin, the following statistics were presented by Dr. Hahn, of his own operations upon the larynx. Read in connection with the statistics lately published in this Journal (vol. i., No. 12, and vol. ii., No. 1), upon *Extirpation of the Larynx*, they are instructive, and we are glad to be able to present a translation of Dr. Hahn's manuscript tables to our readers. We need scarcely remind our readers that Dr. Hahn has, perhaps, a wider experience of these particular operations than any surgeon in Europe, with the exception, perhaps, of Axil Iversen, of Copenhagen, who has, we believe, performed a large number of such operations. The tables here published, and reports of operations which have come to hand since we placed before our readers (*vide supra*) such statistics as could be obtained of all operations of resection of the larynx, serve to justify the conclusions then published in this journal. Even in the hands of such a celebrated and careful surgeon as Prof. Hahn, it is seen that the operation of "laryngofissure" for malignant disease is anything but a slight undertaking, and this bears out the opinions published long ago by v. Bruns and Mackenzie.

The cases of partial excision do not show up very well, and the results are certainly not encouraging. But the results of total excisions assuredly tend to confirm the opinion based upon a large collection of such operations (*vide antea*), and held by many competent surgeons and practitioners, that we have now a number of cases recorded sufficient to enable us to reach the conclusion that total extirpation of the larynx for malignant disease, and especially carcinoma, is an unjustifiable operation. Such an opinion has been freely expressed by several eminent continental surgeons, and all statistics support this view.

I.—Operations for Stenosis and Unilateral Resections.

Name.	Age.	Nature of Disease.	Date of Operation.	Nature of Operation.	Subsequent History.
1. Redtmann.	22	Syphilitic cicatricial stenosis.	7.6.'84	Unilateral resection.	Could hardly make himself understood before. March 1888. Speaks well with Ventil canula, very clearly, and with little effort.
2. Hammer. (Fraulein)	40	Traumatic cicatricial stenosis.	26.1.'85	Extirpation of the cicatricial tissue.	March, 1888. Spur-formation not yet completely removed, in spite of repeated after-operations; speaks and breathes with canula opened above; emphysema and asthma.
3. Ale.	18	Ibid.	30.12.'85	Ibid.	Was treated with the usual bow-shaped canula, which led to the fresh spur-formation.
4. Ibid.	21	Ibid.	5.8.'88	Excision of the whole larynx.	Still under treatment; spurs abundantly removed; still wears the Dup. canula.

II.—Operations for Tumour Formations.

A.—*Extirpation of Tumours from the Interior of the Larynx.*

1.* Scheidenreicht.	51	Carcinoma of the trachea.	8.10.'84	Laryngo-fissure, scraping-out and excision.	Operation. Healed as far as the tracheal opening for the canula. Recurrence. Death through suicide by hanging.
2. Hahn.	37	Carcinoma laryngis.	12.12.'86	Laryngo-fissure, excision and cauterisation.	Cured. Recurrence 1.20.
3.* Richter.	64	Ibid.	6.3.'88	Laryngo-fissure, excision of the thyroid cartilage.	Death on 11th day. Operation only undertaken at urgent request of patient, in spite of cardiac weakness and affection of the kidneys. Death through heart failure and thrombus of the pulmonary artery and infarct. No pneumonia.

B.—*Unilateral Resection of the Larynx.*

4. Steinkraus.	54	Carcinoma laryngis.	11.8.'83	Partial resection.	Cured 28.11.'83; discharged with a canula. Recurrence afterwards, 1.12.
5. W. (Englishman).	52	Ibid.	3.5.'85	Ibid.	Cured in December, 1887; free from recurrence. Operation in private.
6.* J. Kier.	68	Ibid.	8.12.'86	Ibid.	Death after eleven days. No section. Emphysema and bronchitis. Operation in private.
7.* Scholz.	43	Ibid.	29.6.'87	Ibid.	Death on 15th day. "Mediastinitis." Putrid bronchitis. Faulty after-treatment. Insufficient changing of the canula.
8. Kuckein.	36	Ibid.	16.11.'87	Ibid.	12.12.'87. Discharged cured.
9. Tauschwitz.	42	Ibid.	21.2.'88	Ibid.	1.4.'88. Cured. Slight indication of necrosis.

C.—*Total Extirpation of the Larynx.*

10. Schwas.	68	Carcinoma laryngis.	23.10.'80	Total extirpation. ...	March, 1888. Free from recurrence. Speaks in a low tone, but quite intelligibly, with Ventil's canula.
11.* Osterwald.	46	Ibid.	12.8.'81	Ibid.	Went on favourably. Death on 8.9.'81, on the 25th day, from gangrene of the lungs.
12.* Bufé.	58	Ibid.	18.10.'83	Ibid.	Death, 19.11.'83, from pleuritis, and purulent bronchitis.
13.* Freese.	43	Ibid.	11.2.'84	Ibid.	Fresh after-operation for recurrence was borne very well. Death on 10.4.'85, of marasmus.
14.* K. (landed proprietor).	53	Ibid.	12.10.'84	Ibid.	Death, 16.10.'84, from mediastinitis. Canula entered the mediastinum. Operation in private.
15.* Zitzraff (married woman).	52	Carcinoma of œsophagus and larynx.	3.11.'84	Ibid.	Operation performed at urgent request. Good recovery from operation. Death, after several months. Operation in private.

N.B.—The cases which are indicated by the asterisk are those in which death resulted from the operation, or from faulty after-treatment.

C.—*Total Extirpation of the Larynx—(continued).*

Name.	Age.	Nature of Disease.	Date of Operation.	Nature of Operation.	Subsequent History.
16.* Steinkraus.	56	Carcinoma recurrent in larynx.	5.1.'85	Total extirpation.	Death, 15.1.'85, from pleuritis and bronchitis.
17.* G. (Dutch).	43	Sarcoma laryngis.	17.5.'85	Ibid.	Sarcoma, through extension into the trachea. Death from recurrence in five to six months. Operation in private.
18.* Brenke.	60	Carcinoma laryngis.	17.2.'86	Ibid.	Death, 28.2.'86, from pneumonia and erysipelas. Faulty after-treatment. Change of the tampion canula after forty-eight hours. Decubitus of the trachea.
19. Rutschen.	51	Ibid.	29.5.'86	Ibid.	Discharged cured. Recurrence and death probable.
20. Hahn.	37	Recurrent carcinoma.	5.5.'87	Ibid.	Death in four weeks. At the autopsy nothing found to account for death. Lungs intact.

N.B.—The cases which are indicated by the asterisk are those in which death resulted from the operation, or from faulty after-treatment.

NEW INSTRUMENTS AND THERAPEUTICS.

MACKENZIE, HUNTER (Edinburgh).—**Reversible Nasal Saw.** *Lancet, December* 24, 1887.

A DESCRIPTION, with illustration, of a saw which, from its reversibility, is peculiarly adapted for endo-nasal operations. It is made by Mr. Young, Forrest-road, Edinburgh. **G. Hunter Mackenzie.**

BRESGEN (Frankfort a/M).—**Instruments for the Nose and Larynx** *Therap. Monatschr., March,* 1888.

1. DILATOR for the nose (modification of Duplay's speculum). 2. Probes for the nose (for application of cocaine and chromic acid). 3. Chisels for treatment of curvatures of the nose. **Michael.**

SCHECH (München).—**A Cheap Laryngo-phantom.** *Münchener Med. Wochenschr.*, 1888, *No.* 11.

THE phantom consists of a tube of paper, in which a copy of the larynx can be fixed. Thirty copies of the ordinary diseases of the larynx serve to teach these and their treatment. **Michael.**

ROE, J. O. (Rochester).—**An Electric Nasal Saw.** *New York Med. Journ., February* 4, 1888.

THIS is a saw which the author has devised to be worked by an electric motor, and he claims superiority for it over other devices for the removal of bony growths and deformities of the nasal passages, on account of the greater accuracy and rapidity with which the operation can be done. The paper is fully illustrated, and must be read in the original.

Norris Wolfenden.

MAJOR, GEORGE W. (Montreal).—**An Adenomatome.** *Proceedings Montreal Medico-Chirurgical Society,* 1887.

AN instrument on the principle of the guillotine, for removal of adenoid growths when situated high up in the vault. The blades work antero-posteriorly, and are so shaped as to avoid injury to the Eustachian tubes.

G. W. Major.

WHITE, J. E.—Cocaine Spray in Spasmodic and Inflammatory Croup. *Canadian Practitioner, January,* 1888.

THE writer in a letter advocates the use of a 4 per cent. solution, applied by means of an atomizer, and claims for it sedative and astringent properties. **G. W. Major.**

PITTS, BERNARD (London).—**Poisoning by Cocaine, administered subcutaneously.** *Lancet, December* 24, 1887.

IN connection with an annotation in the *Lancet* on the dosage of cocaine (*Journal of Laryngology*, &c., vol. ii., p. 57), the author narrates the case of a boy of thirteen, who, after subcutaneous injection of 1 to 1½ grains of

the salt into a cyst on the forehead, developed very alarming symptoms. Within five minutes of the injection he became pale and restless, with hurried respiration and rapid pulse. These symptoms became more intense, and the patient appeared in great distress. Nausea accompanied by retching and eructations set in, followed by pain over the stomach. Consciousness was unimpaired. The patient was treated with ammonia, brandy, friction over the stomach (this relieved the pain, whilst pressure increased it), and sinapisms to the epigastrium. Recovery in a few hours.

The author remarks that he now no longer regards the drug as free from risk. He will, in future, be more cautious in its use, especially when the patient has not made previous trials of the remedy.

Hunter Mackenzie.

VRUNNELA.—Considerations upon the Application of Hydrochlorate of Cocaine in Diseases of the Throat and Nose. *Rev. de Laryngologia y Rhinologia, March*, 1888.

DR. VRUNNELA, at a meeting of the Institute of Operative Therapeutics, related observations and experiments made with cocaine with regard to laryngology and rhinology. The places touched with the alkaloid became less sensitive, their coloration less red, the salivary secretion more abundant, the respiration easier and deeper, and the patients felt a sensation of coldness and numbness in their throats. He was able to perform the examinations of, and manipulations and operations upon, the fauces and pharynx without the patients' suffering anything; but when he touched with a catheter the laryngeal mucous membrane, the phenomena of reflex origin immediately appeared. Only after four or five touches with a ten per cent. solution was the sensibility abolished. The same effects were observed in the nasal fossæ. He then refers to the numerous applications which can be made with this medicament.

Sota y Lastra.

DODGE, J. L. (Louisville).—**Antipyrine in Asthma.** *New York Med. Journal, February* 18, 1888.

REPORT of a case in which the usual remedies had failed, and in which antipyrine in 50-grain doses effected a cure. **Norris Wolfenden.**

JENNINGS, OSCAR (Paris).—**Antipyrin as an Anodyne.** *Lancet, December* 10, 1887.

AMONGST the diseases in which this remedy was tried was "inflamed painful sore-throat," two cases, one of which was greatly relieved.

Hunter Mackenzie.

MACDONALD, ARCHIBALD D. (Liverpool).—**Sugar and Tea.** *Lancet, December* 31, 1887.

THE excessive use of sugar in any of its forms is a predisposing cause of catarrh of mucous membranes and of eczema, and the recommendation to cease their use altogether, or nearly so, facilitates the cure of these diseases. I can, or think I can, support the foregoing proposition as to catarrh of the air-passages from personal experience, and as to both from observation. **Hunter Mackenzie.**

HEYMANN,— (Cairo).—**The Climate of Egypt.** *Lancet, December* 24, 1887.

ACCORDING to the author, Egypt is a supremely favourable winter resort for the consumptive patient in every stage of the disease. It possesses the two essential characters of such a resort—the power of obviating the disposition to tubercular disease, or the correction of this at its early stages, and the power of mitigating the distressing and wasteful symptoms of the disease when advanced. **Hunter Mackenzie.**

SIMPSON, E. G. (Civil Surgeon, Oudh).—**Treatment of Whooping-cough.** *Prov. Med. Journal, March,* 1888.

IN an epidemic in the Sibsagor district, Upper Assam, the author tried several drugs. Carbolic acid was given as a nervine sedative, and none of the cases treated by other methods "approached the decided and quick benefit derived from it." **Maxwell Ross.**

JEFFRIES, J. AMORY (Boston, U.S.).—**The Anti-Bacterial Action of Iodoform.** *International Journal of the Medical Sciences, January,* 1888.

AS the result of a careful experimental enquiry, the author has arrived at the following conclusions :—

1. Iodoform not being a germicide is not a fit substance to use to procure asepsis of instruments, materials, or wounds.

2. Iodoform is allowable, with the present state of our pharmacopœia, in infected wounds where the true germicides are contra-indicated, as by danger of poisoning or impracticability.

3. As has been long known, iodoform has a decided tendency to stop serous oozing, and therefore may be indicated in wounds where the moisture threatens the integrity of the aseptic or antiseptic dressing.

[Our experience of iodoform in laryngeal phthisis is, that it is an inert and useless drug.] **Hunter Mackenzie.**

GENOIS, LOUIS (Philadelphia).—**Deodorized Iodoform.** *Med. News, February* 18, 1888.

THOUGH iodoform can be deodorized by addition of menthol and oil of lavender, these substances soon volatilize, the odour of iodoform re-appearing. The author has found purified naphthaline, to which a trace of turmeric is added, the best deodorant, and suggests the following formulæ :—

Deodorized Iodoform.

Purified naphthaline	7½ grs.
Powdered turmeric	1½ grs.
Iodoform	91 grs.

Rub together until thoroughly mixed.

Iodoform Ointment.

Deodorized iodoform (as above) . .	ʒij.
Oil of almonds	ʒss.
Lanoline	ʒvss. M.

In making ethereal solutions the turmeric should be left out, as it is not soluble in ether. **Norris Wolfenden.**

DIPHTHERIA.

CHEATHAM, W. (Louisville).—**The Identity of Membranous Croup and Diphtheria of the Larynx.** *American Practitioner and News, February* 4, 1888.

OUCHTERLONY, JOHN A. (Louisville).—**The Non-Identity of Pseudo-Membranous Croup and Diphtheria.** *Ibid.*

THE titles sufficiently indicate the nature of the articles. Dr. Cheatham, towards the end of his paper, says: "In some of my cases of intubation my friends say that it is a case of croup, and if I can relieve the asphyxia (remember the dualist says this is the only way croup kills) the case will get well. I accidentally wound the lip, the tongue, the pharynx, or the tonsil, a true diphtheritic membrane develops on the site of the wound, and we discover it is a case of diphtheria. This has occurred more than once—yes, several times." **Maxwell Ross.**

MINNICH, — (Salzburg).—**On Croup and its Relation to Diphtheria.** *Wiener Med. Klinik,* 1888, *Heft 2 and* 3.

A VERY extensive report on the epidemics of croup and diphtheria in Salzburg, which the author has observed. He differentiates between the two diseases, and says that diphtheria is an inflammation caused by specific bacilli and propagated by infection; the croupous inflammation arises in a traumatic manner by meteoric influences, which have the same effect as traumata. **Michael.**

LUDWIG — (Pontresina).—**On Diphtheria.** *Correspondenzbl. für Schweizer Aerzte,* 1888, *No.* 4.

THE author differentiates between true diphtheria and pseudo-diphtheria. The latter is only found in adults, and is of benign nature. The differential diagnosis between the two forms may often be rather difficult. It is important to observe the pulse, which in even very slight cases of true diphtheria is more frequent than normal. Diphtheria is not a contagious disease in a common sense; the infection of person to person is a rare mode of propagation; only from vaccination, from kissing the patients, or from sucking the canula (as is sometimes done by physicians) is this mode of infection observed. In most cases the miasm lurks in humid portions of houses, as is proved by some cases which are observed continually in humid places. If the condition of the house was ameliorated there were no more cases of diphtheria. **Michael.**

CAILLÉ, A. (New York).—**A Method of Prophylaxis in Diphtheria.** *Med. Rec., February* 18, 1888.

As the result of some experiments of the author, he concludes that if the nasal and oral cavities are kept clean by some harmless, non-irritating antiseptic liquid, the frequency of diphtheritic infection is markedly reduced. Although sanitary and hygienic measures should be rigidly carried out where possible, the utmost importance should be attached to

personal and individual preventive methods. Prophylactic suggestions of simple and practical kinds are not sufficiently dealt with in works on diphtheria. The author passes under review the principal recent works on diphtheria with reference to this point, and concludes with the following practical rules:—In densely populated districts, good house sanitation should be ensured. The over-heating of school-rooms and living apartments is emphatically dangerous. Isolation of the sick should be insisted upon. Enlarged tonsils should be reduced, and carious teeth removed in children, and stopped in the adult. Parents should inspect their children's mouths and throats each day before sending them to school, and children should learn to gargle at an early age. Children with apparently simple sore throat should not attend school until quite well, and preventive measures should be strictly carried out in cases of acute sore throat and follicular amygdalitis. Adults with sore throats should not mingle with children. The kissing of children upon the lips should be forbidden. Children old enough to gargle and rinse their mouths should be taught to do so after each meal, using a weak antiseptic solution; such solutions should be dropped into the nostrils of children each day, or oftener if there is nasal catarrh.

R. Norris Wolfenden.

FERGUSON, JOHN.—A Clinical Study of Fifty-three Cases of Diphtheria. *Canadian Practitioner*, 1887.

As the title indicates, this paper consists of an analysis of fifty-three cases of diphtheria. The treatment prescribed was tincture of iron in full doses every hour. The author condemns the use of chlorate of potash on the ground that whenever administered the amount of albumen in the urine showed an appreciable increase. The mortality was under 10 per centum. The article is interesting, and will repay perusal.

G. W. Major.

MALLOCH, ARCHIBALD E. (Hamilton). — **Experience with Tracheotomy in Diphtheritic Croup.** *Canadian Practitioner*, 1887.

The author strongly advocates the performance of tracheotomy in laryngeal diphtheria. His recoveries have been one in three. He recommends the use of bicarbonate of soda (20 grains to 3j) for the purpose of clearing the tube and of freeing inspissated secretions in the trachea. He tabulates nineteen cases, of which number fourteen died and five recovered.

G. W. Major.

GUTH, RUDOLF (Berlin).—**Statistics of 1,881 Cases of Diphtheria and 1,000 Tracheotomies of the Lazarenkrankenhaus at Berlin** *Report on the Operations performed at the above Hospital*, 1874–1886.

Dr. Langenbech has always introduced an iodoformized sponge or

cotton before the introduction of the canula to prevent the running down of secretions or food. He believes that in this manner he has increased his successes. **Michael.**

WESENER,— (Freiburg).—**Two Cases of Laryngeal Croup with Diphtheria of the Tonsils discovered Post-mortem; with some Remarks on the Relations between Croup and Diphtheria.** *Münchener Med. Wochenschr.*, 1888, *Nos.* 8, 9.

CONTENTS indicated by the title. **Michael.**

WACHSMUTH,— (Berlin).—**Diphtheria, Scarlatina, and Morbilli.** *Deutsch. Med. Wochenschr.*, 1888, *No.* 22.

THE author treats diphtheria by diaphoresis and chlorate of potash, and is content with his results; he cures morbilli and scarlet fever with Mistura solvens. **Michael.**

HOFFMANN-WELLENHOF.—Researches on the Klebs-Loeffler Bacillus of Diphtheria and its Pathogenic Position. *Wiener Med. Wochenschr.*, 1888, *Nos.* 3, 4.

IN eight cases of diphtheria the author succeeded in making cultures of Loeffler's bacillus; in six cultures it was possible to reproduce a diphtheritic affection in animals. After four weeks the virulence of the cultures disappeared. **Michael.**

HEYGATE, W. N. (Bath).—**Diphtheria during Pregnancy.** *Lancet, December* 17, 1887.

NARRATION of a case, seven months pregnant, in which tracheotomy was performed for diphtheria. The author quotes Korotkevich (1887) as testifying to the rarity of this combination (four cases recorded).

Hunter Mackenzie.

VILATÓ.—Dysphonia, Paralysis of the Right Half of the Soft Palate and the Tongue, and General Paresis of the Voluntary Muscles, consecutive to Diphtheria. Treatment by Hypnotic Suggestion. Cure. *Gaceta Médica Catalana, March* 19, 1888.

HISTORY of a girl, seven years old, who in convalescence from diphtheria showed paralytic symptoms in the larynx and fauces, and paretic symptoms in all voluntary muscles, and whose state lasted for a month and a half without any improvement having been observed. Dr. Vilató hypnotized her by the method of Braid, and during her sleep he ordered her to pronounce words in a high and clear voice; he suggested to her the idea of great force in her limbs, and he commanded her to erect her trunk and head, all of which actions the girl performed immediately. She was awakened after seven minutes, and she felt very strong, and retained her voice and power of movement. The following day the hypnotization was repeated with the same results. **Sota y Lastra.**

MacDONNELL, R. L. (Montreal).—**On the Early Loss of Knee Jerk in Diphtheria.** *Medical News, October* 15, 1887.

THE author bases his observations upon eighteen severe cases of this disease. All were hospital cases, and their nature was accurately determined. The author concludes that: 1. In a considerable number of cases knee-jerk is lost from the first beginning of the disease, and thus affords a valuable means of diagnosis of the nature of the throat affection. 2. That loss of knee-jerk is the first evidence of the disease having attacked the nervous system. 3. Absent knee-jerk has no influence on the prognosis.

Norris Wolfenden.

HOLT, EMMETT.—Multiple Neuritis Following Diphtheria; Paralysis, Ataxia, and a Peculiar Deformity of the Neck. *New York Clinical Society. New York Medical Record, January* 14, 1888.

A CHILD had diphtheria in August, and a second attack in October. On December 1 she could not hold the head up, and ataxia appeared; there was slight convergent strabismus; the head could be slightly raised from the chest with difficulty; the muscles of the neck were weak, but mobile. There was marked kyphosis, extending from the fourth cervical to the second dorsal vertebra, and compensatory lordosis of the lower part of the spine. Rigidity was absent, but the parts were tender, and the child had cried with pains in the neck. A smooth, nodular, bony prominence was felt in the pharynx. It was at first suspected that the child had Pott's disease of the cervical region. Knee-jerks were lost. There was no ataxia or paralysis of the upper limbs, and the muscles reacted to weak faradic currents. There was marked tenderness over the sciatic nerve and its branches, and hyperæsthesia of the feet and legs. All the symptoms improved under strychnia.

Another child, brother of the former, after a moderately severe attack of diphtheria, also developed nervous sequelæ (nasal voice, regurgitation of fluids, convergent strabismus, diplopia, etc.). Marked paresis of the lower limbs now followed, with tenderness along the sciatic; knee and plantar reflexes were also abolished. A strong current was required to the legs to produce response. There was no difference between the anodal and cathodal closure contractions. During the two weeks he had been taking strychnine the lower extremities had grown steadily worse.

In the discussion following, Dr. GIBNEY said that, when first he saw the patient he remarked the ataxia, and thought the amount of deformity occurring in so short a time could not be due to Pott's disease. The fact of the deformity having subsequently disappeared, proved it to be of diphtheritic origin. He had seen several cases of ataxia after diphtheria.

Dr. MENDELSON thought ataxia in diphtheritic neuritis to be uncommon. It raised the question of diagnosis between locomotor ataxia and diphtheritic paralysis.

Dr. A. A. SMITH thought that tonics and time did more for diphtheritic paralysis than anything else. Strychnine was only useful as a general tonic, and electricity was useless.

Norris Wolfenden.

LE GENDRE.—The Antiseptic Treatment of Diphtheria. *Archives de Laryngologie, No.* 1, 1887.

THE following formulæ for prescriptions are given :—

1. *Bichloride of mercury.*

℞ Aquæ distill. ℥ 3¾.
Tinct. aconiti. ♏ 15—30.
Sodii chlorid.
Pepsine āā gr. ¾.
Hydrarg. bichlor. gr. $\frac{1}{6}$—2¼. *M.*

A teaspoonful every hour.

2. *Cyanide of mercury.*

℞ Aquæ distill. ʒ 15.
Tinct. aconiti. ♏ 15.
Hydrarg. cyanid. gr. $\frac{1}{10}$. *M.*

A teaspoonful every hour.

3. *Iodoform.*

℞ Ether ʒ 6¼.
Balsam Tolu ♏ 75.
Iodoform gr. 38.

The pharynx may be pencilled every two or three hours.

4. *Bromine.*

℞ Bromine (puris).
Potass. bromidi. āā gr. 8—15.
Aq. distill. ʒ 50.

For pencilling the pharynx ; or for inhalation.

5. *Sulphur.*

℞ Ol. amygdal. dulc. ℥ 5¾.
Sulphur. sublim. gr. 38.

To be used as a gargle.

6. ℞ Calcii. sulphid. gr. ¾.
Digitalin.
Quiniæ arsen. āā gr. $\frac{1}{60}$.
Pil. ft. (Half this dose for infants.)

This pill is said to have given good results.

7. *Salicylic acid.*

℞ Aq. distill. ʒ 25.
Glycerin. ʒ 2½.
Aq. lauro-cerasi ♏ 15.
Acid. salicylic. gr. 4½

Applied on cotton wad to the pharynx.

8. *Benzoate of sodium.*

℞ Aq. distill.
Aq. menth. pip. āā ʒ 10.
Syrup. aurant. cort. ʒ 2½.
Sodii. benzoat. gr. 75.

Half a teaspoonful to a dessertspoonful hourly.

9. *Lactic acid.*

℞ Aquæ. ʒ 25.
Syrup. aurant. ʒ 7½.
Acid. lactic. gr. 75.

As a gargle or spray.

10. ℞ Glycerin. ʒ 15.
Acid lactic. gr. 45.

For touching diphtheritic ulcers.

11. *Oxalic acid.*

℞ Infus. of green tea ʒ3 2½.
Syrup. aurant. cort. ʒ 7½.
Acid oxalic. gr. 23.

A teaspoonful to a dessertspoonful every three hours.

12. ℞ Acid. oxalic. 1.
Glycerini. 100.

For local use.

13. *Carbolic acid.*

℞ Acid carbolic ʒ 70.
Acid salicylic ʒ 14.
Acid benzoic ʒ 28.
Alcohol ʒ 117.

Use as a spray.

14. ℞ Succi citronis ʒ 75.
Sodii chlorid.
Sodii sulphat. āā ʒ 2½.
Mel. ʒ 3¾.
Syrupi. calcis. ℥ 30—60.
Sodii. carbolat. gtt. 20—30.

A teaspoonful or dessertspoonful every two hours.

15. ℞ Aq. calcis. ʒ 30—75.
Liq. ferri. chlor. ℥ 30—120.
Acidi. carbol. gr. $\frac{9}{10}$—15.
Mel. rosat. ʒ 7½.

For local application to the pharynx, etc.

16. ℞ Sodii borat.
Potass. chlorat. āā gr. 75.
Acidi carbolic gr. 4.
Glycerin. ʒ 2½.
Mel. ʒ 7½.

For local application.

17. ℞ Tinct. krameriæ ʒ 2½.
Tinct. benzoin ♏ 75.
Tinct. aloes ♏ 45.

The tonsils and pharynx may be touched three times daily with this mixture, and the following powders then be insufflated—

℞ Tannin gr. 23.
Sulphur sublim.
Pot. chlorat. āā gr. 30.

Norris Wolfenden.

HOGEBOOM, C. L. (Jamaica).—**The Treatment of Membranous Croup with Bicarbonate of Soda.** *New York Medical Record, March* 3, 1888.

THE author treated a patient (a child of three) with eighty grain doses of bicarbonate of soda, dissolved in half a teaspoonful of water, to which a tablespoonful of milk was added. This was followed by thirty grain doses every hour until the laryngeal symptoms abated. Weak milk and water was also given, and warm fomentations applied to the throat.

Norris Wolfenden.

NOSE AND NASO-PHARYNX.

GOODWILLIE, D. H. — Nasal Intubation. *New York Med. Journal, February* 4, 1888.

THE author is in the habit of using oval-shaped tubes of the same size with the exception of the anterior end, which is shaped to fit the rest of the nostril: the tubes are made in soft rubber, platina, or aluminium, of different sizes, ¼ inch to ½ inch in diameter and 2½ to 3½ inches long. They are more comfortable if the anterior end be made of soft rubber. The tube is passed into the inferior meatus, the anterior end resting in the vestibule; it can be worn comfortably, is not seen externally, and can be readily removed by the patient for cleansing and returned into the nostril. The small rubber tubes are used at the commencement of the treatment, and changed to larger ones until there is normal space, or the deformity has been corrected. They are useful in the following cases:—Intra-nasal hæmorrhage; internal and external fractures of the nose; deviations of the septum (after removal of exostosis) after removal of hypertrophic tissues or polypi; hypertrophies of the soft tissues without operation. Worn for a sufficient time they produce absorption. Two cases are related by the author, in which the method was used with advantage. Norris Wolfenden.

MAJOR, GEORGE W. (Montreal).— **Chronic Nasal Catarrh: its Nature and Treatment.** *Canada Medical and Surgical Journal*, 1887.

A CLINICAL lecture at the Summer Session of McGill University.

MAJOR, GEORGE W. (Montreal).—**Removal of a Foreign Body from the Nose.** *Canada Medical and Surgical Journal*, 1887.

THE foreign body was a metallic boot button, and had been *in situ* for seven years, and had become thickly incrusted with phosphate of lime. This rhinolith was embedded in the soft tissues, and was firmly impacted between the lower turbinated bone and the floor of the nasal chamber.

When an offensive or any discharge is confined to one nostril, the presence of a foreign body should always be suspected. **G. W. Major.**

JOHNSTON, WYATT G. (Montreal).—**Mucous Polypi.** *Proceedings Montreal Medico-Chirurgical Society, March*, 1888.

THE author pointed out that in eight or nine cases under notice (specimens of which had been sent him for microscopic examination) the condition was seen in its early stage, and was found to be strictly an adenoma of the nasal mucous glands. In later stages in the epithelia there is a more or less complete disappearance of cell outlines, leaving only areolar tissue infiltrated with mucous fluid.

The secondary change probably accounts for the reason why these growths are commonly but incorrectly called myxomata of the nose, and confused with true myxomata which are tumours of quite a different nature, originating in connective tissue. **G. W. Major.**

KAYSER (Breslau).—**On the Significance of the Nares and the Upper Respiratory Tracts for Respiration.** *Archiv für die ges. Physiologie, Bd.* 41.

THE air inspired by the nose has half per cent. higher temperature than that which is inspired by the mouth. In one day the air inspired by the nose is mixed with 540 grm. of water. Of the organic and inorganic constituents of the air, the greater portion is retained by the mouth and pharynx; only a small portion enters the lungs. **Michael.**

KONIG (Göttingen).—**New Proceeding in Operating upon Retro-Nasal Polypi.** *Centralblatt für Chir.*, 1888, *No.* 10.

THE dorsum nasi is cut on one side with scissors. It does not matter greatly whether this operation is done on the right or on the left side. An operation upon the osseous parts is unnecessary in most cases. To remove the neoplasms the author applies large sharp spoons. This instrument is introduced by the nose, and the polypus removed by cutting. Having finished the operation the wound of the nose must be sewn up. The author also uses the spoon for the removal of ordinary nasal polypi. **Michael.**

WALLE (Bonn).—**Clinical Remarks on Diseases of the Nose and Pharynx.** *Bonn*, 1888. 87 *pages.*

I. *Twenty-five Cases of Operative Opening of the Antrum of Highmore.*—In all cases the empyema was not caused by continuation of the purulent process from the nose, but by caries of the teeth. By opening the alveolus of the extracted carious tooth the pus was removed, and the cavity was cleansed with salt solution.

II. *On Bursitis Pharyngea.*—Communication of forty cases of this disease; some of them were cured by galvano-cautery, the greater number by nitrate of silver.

III. *On Ozæna.*—The author believes that ozæna is caused by a micro-organism. The atrophy is not the cause of the fœtor.

Michael.

FREUDENTHAL (New York).—**On the Relation between Chronic Obstructions of the Nose and Naso-Pharynx and Abdominal Hernias.** *Monatschr. für Ohrenheilk., &c.*, 1887, *Nos.* 11, 12; 1888, *Nos.* 1, 2.

A CASE of the greatest interest. The patient, sixty-four years old, became ill with cough, dyspnœa, and blood-spitting. The laryngoscope showed nothing unusual, but there was no respiratory sound in the right lung. The right side of the thorax did not move at all; fremitus and bronchophony were not remarked on the right side; the percussion of this side was dull. Some weeks later the patient died. The post-mortem examination, performed by Prof. Weigert, gave the following result: The trachea was embedded in masses of tumour. A part of the tumour had perforated the trachea and filled the lumen of the right bronchus. The lung contained no air. The microscope showed that the tumour was a carcinoma. From the absence of the respiratory murmur, the result of the percussion and the diminution of the volume of the right lung, the diagnosis of complete atelectasis of the lung could have been made "intra vitam."

Michael.

McDONAGH, G. R. (Toronto).—**Rhinoscleroma.** *Canadian Practitioner*, 1887.

A GOOD review of the subject, containing no original matter.

G. W. Major.

PRINGLE, I. H. (Edinburgh).—**Note of a Curious Accident.** *Edinburgh Medical Journal, December*, 1887.

IN this case two splinters of wood struck the patient, who was employed at a saw-mill, just below the nasal bones. "From the articulation between the nasal bones and cartilages there was a lacerated wound running down to the right angle of the lower jaw. From just below the nasal bones the two splinters of wood projected, the shorter passed straight back through the nasal cavity, the longer down under the cheek, and projected through the skin at the left angle of the lower jaw." In order to detach the short splinter the hard palate had to be split up, and the superior maxillæ kept apart. On account of swelling about the fauces

tracheotomy was necessary. Temporary relief was given, but the patient died in a few hours.

Inspection showed that "the turbinated bones, vomer, and right superior maxilla communicated. The hard palate was transversely fractured, but the mucous membrane was not involved. Epiglottis and back of tongue seemed normal; soft palate slightly ulcerated; brain and skull uninjured." The splinter which had entered the nose was $5\frac{1}{2}$ inches in length, and of this $4\frac{3}{4}$ inches had been buried in the nasal cavity.

Hunter Mackenzie.

MOUTH, TONSILS, PHARYNX, &c.

BARKER, ARTHUR E. (London).—**Removal of Part of the Jaw, Tongue, Side of the Pharynx, and Soft Palate for Epithelioma.** *Lancet, December* 3, 1887.

THIS case is stated "to illustrate some of the advantages of division of the cheek for the purpose of reaching disease far back in the tongue and pharynx." About a year after the operation the disease returned in the throat, with ulceration and hæmorrhage, and death ensued three months subsequently after a severe attack of bleeding.

The author remarks upon the fact that, up to the end of the case, no extension of the disease to the glands could be discovered. The result in regard to complete relief from suffering and prolongation of life in this and in other cases inclines the author to the opinion that more might be done in the way of excision of pharyngeal cancer than is commonly supposed.

Hunter Mackenzie.

PADLEY, GEORGE (Swansea).—**The Treatment of Cancer.** *Lancet, December* 24, 1887.

IN the course of a discussion which followed upon the publication of Mr. Clay's paper on this subject (*Vide Journal of Laryngology*, &c., vol. II, p. 109), the case is related by Mr. Padley of a patient, aged sixty, who suffered from a painful indurated tumour on the side of the tongue, extending from near the root to within two inches of the tip, and occupying nearly one-half the transverse diameter, with hard, raised, and everted edges. Chian turpentine was used, and after about two months' trial the diseased mass, which had been progressively increasing, appeared to be less active, and after a further period the surface presented a less malignant aspect, the ulcer appearing less deep, and its edges less

raised and everted. The improvement continued to be marked, both as to the appearance of the local disease, the diminution of pain, and the power of swallowing and of speech (which had become nearly unintelligible)." At this stage the patient unfortunately died of syncope. The author has the impression that the disease would have subsided if the strength had been sustained.

[We have lately had an opportunity of trying the effect of Chian turpentine in a similar case, without the slightest appreciable result from its prolonged and careful administration.] **Hunter Mackenzie.**

BARWELL, RICHARD (London).—**Clinical Lecture on a Method of Excising the Tongue.** *Lancet, December* 31, 1887.

THE following is the method :—"Strictly in and along the middle line an opening is made about one-third of an inch long immediately in front of the hyoid bone, through the raphé of the mylo-hyoid. The genio-hyoid and genio-hyo-glossus are separated with the handle of the scapula until the deep surface of the mucous membrane forming the floor of the mouth is reached. By means of Liston's needles carried under this membrane to, or even beyond, the last molar tooth, threads are passed on each side into the buccal cavity, which, in their turn, draw flexible wire-twist first into, then out of, the mouth, in such wise as to surround the base of the tongue as far back as one will. An écraseur working with this wire, severs that part of the organ. Then the loop of another écraseur is passed between the teeth, pressed well down on the first incision, and divides the structures beneath the tongue."

The advantages claimed for this method by the author are bloodlessness, great security against septic pneumonia from the thorough drainage allowed by the supra-hyoid wound, and painlessness of the stump from its non-possession of sensory nerves. **Hunter Mackenzie.**

BROSIN.—**Black Tongue.** *Monatschr. für Prak. Dermat.*, 1888. *Appendix.*

HAVING reported the cases known up to now, and the different views held on the nature of the affection, the author relates three new cases. The first was a lady fifty-two years old, who had a black tongue, without pain, and only experiencing a bad taste in the mouth. For two years the condition remained the same, except for an acute gastric disorder. She gargled with chlorate of potash, and the affection disappeared.

Of the second case the author has specimens from the Pathological Institute of Dresden. The elongated appendices of the epithelium are coloured intensely black. The third case occurred in the practice of Prof. Geuzner, and he cured it by removing the black surface with the sharp spoon. A very careful study showed that micro-organisms were

innocent of this disease, but that there was an increased formation and cornification of the epithelial appendices of the filiform papillæ. Old cornified epithelia have a dark colour, which is not caused by coloration of medicaments or nutriments. The affection must be viewed as a hyperkeratosis. **Michael.**

BEISSEL (Aachen).—**Syphilitic and Mercurial Ulcers of the Tongue.** *Monatschr. für Dermat.*, 1888, *No.* 6.

It is of great importance to differentiate between these causes of ulcers. Mercurial ulcers are mostly combined with swelling of the whole tongue and affections of the gums. Syphilitic ulcers are isolated, and mostly without inflammation of the circumference. In dubious cases the mercurial treatment should be stopped. Syphilitic ulcers become worse if they are treated with nitrate of silver. (?) Mercurial ulcers can be improved by this medicament. Syphilitic ulcers must be locally treated with chromic acid. **Michael.**

PETERSEN (St. Petersburg).—**On Extra-genital Syphilitic Infection.** *Monatschr. für Dermat.*, 1888, *No.* 7.

The author gives a statistical review of the cases of extra-genital syphilitic affection which occur very often in Russian provinces. He relates a case of primary syphilitic infection of the gums, originating from the use of an instrument for the extraction of a tooth. **Michael.**

ENGEL VON, G.—On the Prophylaxis of some Diseases of the Mucous Membrane of New-born Children. *Wiener Med. Presse*, 1888, *Nos.* 8, 9.

To prevent soor it is necessary to forbid the cleaning of the mouth with handkerchiefs. This manipulation favours the disease in two ways. First, the membrane is wounded and a way opened for the entrance of the affection; secondly, handkerchiefs, if not very well disinfected, may directly propagate the micro-organism of the disease. **Michael.**

LUCAS, R. CLEMENT (London).—**Epithelioma of the Lip and Glands. Recurrence after Removal. Excision of the Growth with two inches of the Internal Jugular Vein. Exposure of the Deep Vessels and Nerves. Pneumogastric Symptoms. Recovery.** *Lancet, December* 31, 1887.

The nature of the case is indicated by the title. "After the patient had been put back to bed, the effect of the irritation of the pneumogastric was evidenced by syncope, and a pulse of only forty-four. The pathological specimen was interesting, as showing the little resistance the coats of a vein offer to the inroad of cancer, compared to those of an artery when equally exposed." **Hunter Mackenzie.**

ROBERTSON, WILLIAM (Newcastle-on-Tyne).—**Hypertrophy of the Lingual Tonsil. Use of Galvano-Cautery. Recovery.** *Lancet, December* 31, 1887.

THIS case is identical in every respect with that reported in the *British Medical Journal*, Nov. 19, 1887, and has been already noticed in our columns (Vol. II., p. 117). **Hunter Mackenzie.**

DUNCAN, T. H. (Chatham).—**Complete Adhesion of the Soft Palate to the Posterior Pharyngeal Wall, with consequent Partition of the Post-Nasal Cavity from the Mouth.** *Canadian Practitioner, January*, 1888.

THE title explains the condition. The palate was divided at the site of the adhesion, and dilatation was maintained. The result was satisfactory. **G. W. Major.**

BLAIRS, LOUIS E., M.D. (Albany, New York).—**The Dangers of Hæmorrhage after Tonsillotomy.** *Albany Medical Annals, February*, 1888.

THE author relates two cases in young men occurring after removal with Mathieu's tonsillotome. Various astringents were applied, but ice and pressure were found most efficacious. He attributes the hæmorrhage to the use of cocaine, of which ten and twenty per cent. solutions were injected into the tonsils. "After the first effects pass off, occasionally the vessels seem to be paralysed for a time, and the contractility is greatly diminished, while the vessels, remaining open, provoke a profuse bleeding." **Maxwell Ross.**

BROWNE, LENNOX.—On an Unrecognized Cause of some Throat Ailments. *Prov. Med. Journal, November*, 1887.

GLOBUS hystericus and other subjective sensations in the throat are very rarely hysterical or phantom in character. The author has found when such sensations were complained of, a varicose, sometimes hæmorrhoidal, condition of veins at the base of the dorsum of the tongue, an enlargement of the circumvallate papillæ, and a fulness of the thyroid isthmus. Treatment consists of the internal administration of chalybeates and aperients with digitalis or ergot as may be indicated. Locally astringent applications, muriate of ammonia tablets, and for varicosities and hyperæmic tumefactions, the galvano-cautery points are found useful. **Maxwell Ross.**

WAY, J. H. (Waynsville, N. C.).—**A Case of Death from Suffocation by Phlegmonous Tonsillitis.** *Med. Rec., February* 25, 1888.

THE cause of death in this case was the entering into the larynx of a large quantity of pus and broken-down tonsillar tissue derived from the rupture of the right tonsil. **Norris Wolfenden.**

PETCZYNSKI.—Acute Pharyngitis, with General Desquamation of the Epidermis. *Gazeta Lekarska, No.* 3, 1888.

A DESCRIPTION of a rather curious case. A healthy man, aged thirty-five had been subject for several years, in the spring and autumn, to sub-maxillary adenopathy followed by desquamation of the epidermis in plaques covering the whole surface of the body as completely as in scarlatina. This lasted for four days. **Constantin Karwowski.**

OLTUSZEWSKI.—A Case of "Mycosis Pharyngis Leptothricia." *Gazeta Lekarzka, No.* 4, 1888.

DESCRIPTION of a case of this disease in a patient, aged sixteen, in whom the affection appeared suddenly on the tonsils, the arches of the palate and the tongue, accompanied by intense fever. The author has had the patient under his care for six months. He took away the excrescences with the forceps, and ordered gargarisms of corrosive sublimate 1/2000, but without success: fresh colonies of leptothrix appearing always. The author afterwards gives the differential diagnosis of the disease. **Constantin Karwowski.**

SOTA.—Two Cases of Œsophagotomy for Removal of Bones. *Revista Médica de Sevilla, January* 15, 1888.

A NUN swallowed a piece of bone while she was sucking it. Great pain and difficulty of respiration suddenly appeared; she was not able to swallow even a few crumbs of bread; several draughts of water went down with trouble, and others were thrown up by the mouth and the nose. She and many persons put their fingers into the pharynx of the patient, scratching the mucous membrane, then a wax candle was introduced into the œsophagus, and with it the foreign body was shoved down. The pains which the nun felt obliged all manipulation to be stopped. After twenty days, Sota performed external œsophagotomy, and withdrew a chicken bone. The patient was cured completely in three months. The second case was that of a gipsy, who swallowed a piece of sheep's vertebra. The same manipulations were made with this patient as with the nun, and at the end of one month Sota saw him, and performed external œsophagotomy, extracting from the gullet a very irregularly shaped bone. The man was cured in twenty-one days.

The author says that in these cases all violent efforts to push down or to draw out the foreign body are hurtful, and we must perform the operation as soon as possible; it has been thought that it would be better not to give chloroform; the separation of tissues with the fingers after cutting through the skin and aponeuroses is the best guarantee of passing without danger through the space which it is necessary to pass in order to arrive at the required point; the introduction of a large catheter into the œsophagus makes the finding of this point easy; absolute abstinence abridges the cure; suture of the œsophagus is difficult, and probably inefficacious; and the permanent catheter is not only troublesome, but also pernicious.

Sota y Lastra.

STROEM, H. (Christiania).—**Foreign Body in the Œsophagus. External Œsophagotomy. Cure.** *Norsk Magazin for Laeger, December*, 1887.

THE patient, a male lunatic, aged twenty-eight, tried to commit suicide by swallowing a large stone, weighing 50 grammes, and being 5·1 centimètres long, 2·7 broad, and 2·8 thick. By external œsophagotomy, which was performed twenty-three hours after the occurrence, the stone was removed with some difficulty, owing to its large size and deep position, being situated at the level of the second rib on the left side. For the first two days the patient was nourished by clysmata, the third day the patient could take liquid food, and a fortnight later he had recovered. The wound in the œsophagus was united with catgut.

Holger Mygind.

OPITZ (Chemnitz).—**On Blind Ending of the Œsophagus, and the Nature of Amniotic Fluids.** *Allg. Deutsche. Hebammenzeitung*, 88, *No.* 1.

A CHILD, aged four days, normal to all appearance, vomited all fluids which it retained for a short time after swallowing them. A probe could be introduced into the œsophagus only as far as the cricoid cartilage. The child died some days later, and the post-mortem examination showed the œsophagus ending in a *cul-de-sac*. The intestines were filled with meconium. The case showed that the amniotic fluid has nothing to do with the nutrition of the fœtus.

Michael.

LARYNX.

PALMER, A. L. (Toronto).—**Intubation of the Larynx.** *Canadian Practitioner*, 1887.

THE author reports a case of intubation of the larynx in a child aged five years, the subject of diphtheria. The patient died twenty-eight hours after the operation from lung complications. The post-mortem examination showed the membrane extending beyond the point reached by the lower end of the tube. Attention is called to the danger attending the prolonged attempt at introduction of the tube, as also to the risk of giving liquid nourishment.

G. W. Major.

ATHERTON, A. R. (Toronto).—**Case of Fracture of the Larynx.** *Canadian Practitioner*, 1887.

A CASE of fracture of the larynx, the result of mechanical injury. Breathing became instantaneously difficult, the face, neck, and chest enormously swollen. The extension downwards of the emphysema was arrested by

the waist-band of the trousers. The superficial wound was half an inch in extent. Tracheotomy was performed, and a good recovery ensued.

G. W. Major.

SCHWEIG, H.—Some of the Causes of Vocal Disturbance. *New York Medical Journal, January* 28, 1888.

THE author warns against the too common practice of treating the upper air passages by energetic surgical methods. He has for some years placed reliance on constitutional local treatment in a great many cases of vocal disability. He finds many cases originating in uterine and ovarian disorders, and gastric disturbance, persistent constipation, and other causes of disturbance of the general health. Others owe their origin to the abuse of tobacco and alcohol as specific catarrh, leading to slow changes in the structure of the lining membrane of the throat, malaria, rheumatic tonsillar affections.

The abuse of surgical methods, galvano-cautery, and caustics, sometimes leads to cicatricial contractions exerting a deleterious effect on the voice. Constitutional treatment should always be adopted, and the author warns against the danger of accepting that which is discovered by the laryngoscope as necessarily a primary ailment.

Norris Wolfenden.

MAJOR, GEORGE W. (Montreal).—*Proceedings of the Montreal Medico-Chirurgical Society*, 1887.

1. A LARGE papillomatous growth removed with Schrötter's forceps, and afterwards curetted.

2. Cyst of vocal cord. The cyst was situated on the free margin of the right vocal cord, very far anteriorly. The voice was not under control. The tumour was removed with Mackenzie's antero-posterior cutting forceps. An immediate restoration of natural voice was the result, a condition absent for seventeen years. Dr. Wyatt Johnston reported the boundaries of the cyst as distinctly formed of fibrous tissue, with a thin layer of epithelium over the inner surface. The cyst probably originated in inflammatory obstruction of one of the mucous glands. The voice has remained permanently good, and is now under perfect control.

G. W. Major.

SREBRNY.—Pharyngeal and Laryngeal Tuberculosis, and New Methods of Treatment. *Gaz. Lekarska, No.* 9, 1888.

THE author after having reviewed the different methods for the local treatment of infiltrations and tuberculous ulcerations, and after having stated that all these methods are good, and give positive results, and that the cure of tubercular laryngeal ulcerations is already an incontestable fact, arrives at the conclusion that to cure also phthisis of the lungs one ought to try (following Reichert's idea) to reach the lungs with parasiticide fluids, with this modification of the original idea—that before beginning this treatment tracheotomy should be performed on the patient, and the end of the pulverisator should be introduced through the opening of the

tracheotomy canula, and not through the glottis as was done by Reichert. The author thinks that the first attempts of this kind should be made on phthisical patients tracheotomized on account of stenosis of the larynx.

Constantin Karwowski.

MAJOR, GEORGE W. (Montreal).—**Arytenoid Disease.** *Proceedings Montreal Medico-Chirurgical Society*, 1887.

THE subject was illustrated by a number of demonstrations. The object of the communication was to point out the comparative frequency of disease of the arytenoid joint, and to call attention to the fact that a percentage of cases described as of the nature of paralysis were, in point of fact, anchylosis of the crico-arytenoid joint, of greater or less degree.

G. W. Major.

MAJOR, GEORGE W. (Montreal).—*Proceedings Montreal Medico-Chirurgical Society*, 1887.

1. COMPLETE paralysis of right vocal cord, resulting from pressure of a fibroid tumour on the recurrent nerve. 2. Early laryngeal œdema (tuberculous), with an absence of lung signs. 3. Three cases of laryngeal papillomata. 4. A laryngometer: A mirror, engraved on its reflecting surface, for making measurements in the larynx. G. W. Major.

STOERK (Vienna).—**The Cause of the Shock following Extirpation of the Larynx.** *Wiener Med. Wochenschr.*, 1888, *No.* 12.

AFTER extirpation of the larynx death follows from paralysis of the heart. The author says that this is caused by the destruction of the ramus cardiacus nervi vagi which sometimes is imbedded in the mucous membrane of the posterior laryngeal wall. Whenever possible, therefore, this part of the mucous membrane should be preserved. Michael.

LEWIN, G. (Berlin).—**Contribution to the Knowledge of Perichondritis Laryngea, with Special Relation to Syphilis.** *Charité Annalen*, 1887.

THE author refers to a case of idiopathic perichondritis with necrosis of the left part of the cricoid cartilage. The case has been diagnosed as syphilitic and treated in this manner. Primary perichondritis differs in some points from the secondary form. The swelling of the parts is characteristic; an abscess often follows. As consecutive affections, œdema of the larynx and ankylosis of the crico-arytenoid articulation are often seen. In cases of stenosis tracheotomy must be performed and abscesses must be opened. In specific perichondritis an anti-syphilitic treatment must be administered. Michael.

BOSLEY, G. H. (New York).—**A Case of Laryngeal Stenosis due to Compression by Goître. Operation. Recovery.** *New York Med. Journ.*, *January* 28, 1888.

THE author thinks this the first case in which laryngeal stenosis has been reported due to a hypertrophied thyroid gland, several such cases

having been recorded in which the gland was affected with malignant disease. Sudden asphyxia being imminent, the author with a scalpel made an incision on to the trachea, at the upper border of the tumour, cutting through an inch of the enlarged gland. In consequence of collapse of the tracheal walls lower down preventing the entry of air, the author inserted into the trachea, a Jacques' catheter with its end cut off, which he passed into the obstruction, and which was replaced by a No. 10 English gum catheter, and later on by a Koenig's silver tracheal tube. Subsequently the enlargement was treated by injections of tincture of iodine. She wore the silver tube eight months; on attempting to remove it the trachea again collapsed, and it had to be re-inserted. Seven months after the long tube was removed and the short one inserted, the patient having meanwhile been put on treatment with lacto-phosphate of lime (to harden the tracheal rings), acetate of iron and quinine: five weeks afterwards the short tube was also dispensed with; a week afterwards the tracheal wound was completely closed, the neck of normal size, and "laryngoscopic examination showed the larynx and trachea perfect in every respect." **Norris Wolfenden.**

POLLAK (Prague).—**Contribution to the Knowledge of Early Forms of Laryngeal Syphilis.** *Monatschr. für Dermat.*, 1888, *No.* 7.

(1) MACULA syphilitica were seen in eleven cases. They are now seen only in a few cases because they do not generally cause any symptoms, and are only found by systematic laryngoscopical examination of all syphilitic subjects.

(2) Papulæ laryngis were seen in ten cases.

(3) Catarrhus syphiliticus. From the laryngoscope merely, it is rather difficult to differentiate between common and specific catarrhs. The latter are, in most cases, more circumscribed and more often combined with ulcers and erosions. The diagnosis is confirmed by the prompt effect of anti-syphilitic treatment. Eleven per cent. of all syphilitic patients examined have had an affection of the larynx. **Michael.**

SOKOLOWSKI.—Contribution to the Casuistics of Laryngeal Polypi. *Gazeta Lekarska, No.* 9, 1888.

A DESCRIPTION of twenty cases of laryngeal polypi operated upon by the author at the Hôpital de Ste. Esprit, at Warsaw, and in his private practice. Amongst these polypi were fibromata, fibro-angiomata, fibro-myxomata, and papillomata. He has operated upon them all by extirpation, with Fauvel's or Mackenzie's forceps. In two cases he practised with Voltolini's sponge method successfully. In one case of multiple papillomata in a child of five years old causing suffocation, he was obliged to have recourse to thyrotomy, and to extirpation of the polypi by this means. **Constantin Karwowski.**

McDONAGH, G. R. — Primary Tuberculosis of the Larynx. *Canadian Practitioner*, 1887.

THE writer considers laryngeal tuberculosis from a diagnostic point of view in its relation to pulmonary phthisis. He quotes two instances of primary laryngeal tuberculosis.

In the first case referred to, extensive alteration of the larynx existed without at any time lung signs. In the second case quoted, death occurred from Bright's disease. At the post-mortem examination the larynx presented signs of tuberculosis, and microscopic investigation proved the presence of tubercle bacilli. The lungs were found free from indications of phthisis. During life slight aphonia had existed.

G. W. Major.

INGALS, E. FLETCHER (Chicago). — **Rheumatic Laryngitis.** *International Journal of the Medical Sciences, January*, 1888.

THE author describes his complaint as "a painful affection of the vocal organ, attended by more or less hoarseness and fatigue of the parts after talking, and sometimes by grave, or even fatal obstruction of the glottis. It may be either acute or chronic."

The author has been able to find two articles dealing with the acute variety, but the chronic seems to have been hitherto quite unrecognized. This (the chronic) variety "usually occurs in a person of rheumatic diathesis, but often the larynx or the tissues about the hyoid bone present the only evidence of the constitutional affection. The pain is not constant, but may frequently disappear for a few days, especially during fine weather, to return again on slight exposure, or with changes in the temperature. Its course is erratic, but nearly always obstinate." The pain may be vocal or deglutitory, and may be located in any part of he throat. Hoarseness, loss of voice, and vocal fatigue may be present.

The laryngoscopic appearances are not characteristic—intra-laryngeal swelling or congestion may or may not be present.

The complaint is most liable to be confounded with neuralgia or paræsthesia of the organ. The history may help in the diagnosis, as may also the result of treatment.

In regard to treatment, the author has seen considerable benefit ensue from the local application of stimulant and astringent sprays, or pigments, or the galvano-cautery. He has mainly relied, however, upon internal remedies suited to the diathesis. Hunter Mackenzie.

MAJOR, GEORGE W. (Montreal).—**Removal of a Nut-shell Impacted in the Larynx.** *Canadian Medical and Surgical Journal*, 1887.

PORTION of an almond shell, impacted between the vocal cords posteriorly, was removed by means of a probe bent at a suitable angle, and introduced beneath the obstruction. The infant was eleven months old.

G. W. Major.

PIENIONZCK.—The Extraction of a Pin Three Centimètres long from the Right Secondary Bronchus. Cure. *Przeglond Krakowski*, 1887, *Nos.* 47, 48.

A BOY, fourteen years old, was amusing himself by shooting an arrow by blowing it out of a paper tube. He had made the arrow out of a cartridge, through which he had stuck an ordinary pin three centimètres long. In order to make the inside of the cartridge solid, in which was the head of the pin, he had filled it with paper. It happened that whilst holding the tube in his mouth, instead of blowing out he swallowed the arrow. Feeling it in his throat he tried to withdraw it with his fingers, but the moment he touched it the arrow disappeared. The fourth day after the accident the patient consulted the author complaining of a severe continuous pain in the back located at the level of the fourth cartilage on the right side. The author by auscultation found stenosis of the right bronchus, and guiding himself by the anamnesia diagnosed the foreign body to be located in the bronchus. The larynx and trachea, which could be seen as far as the bifurcation, presented a normal appearance. In this state of things the author proposed to the patient to perform tracheotomy and to extract the arrow from the bronchus through the opening of the wound. The following day, when examining the patient with other doctors it was found that the foreign body had already sunk lower into the secondary bronchus, and that inflammation was beginning to set in, in the inferior lobe of the lung. Tracheotomy was then performed at once. The author introduced a very flexible pair of forceps into the opening of the wound (forceps of his own invention for laryngeal polypi) bent according to the natural shape of the bronchus, and after several trials he had the good fortune to reach the secondary bronchus, and to extract from it the arrow by its sharp end which fell exactly within the range of the forceps, lying in their axis. To catch hold of the arrow the author was obliged to insert the forceps 20 centimètres deep, counting from the opening made by tracheotomy. The patient was only confined to bed for six days, at the end of which time the lung resumed its normal condition, and the wound cicatrized by first intention. The author then reviewed the literature of foreign bodies in the bronchi, and the methods and attempts, more or less successful, to extract them. He himself has often extracted from children who have been tracheotomized, croupous membranes from the secondary bronchi. In order to examine the trachea by the opening made by tracheotomy he employs Zaufal's canulas from 6 to 8 centimètres long.

Constantin Karwowski.

JURIST, L.—A Case of Round-celled Sarcoma of the Larynx. *Med. News, October* 22, 1887.

THE patient, aged sixty-five, had suffered for two years from occasional attacks of sore throat, had no pain, but complained of food "going the wrong way" during the latter five or six weeks. He had also lost weight. Family history excellent. No glandular enlargement. There was dyspnœa. A smooth, globular, non-ulcerated growth, of grey tint and dense consist-

ence, and of the size of a horse-chestnut, was found laryngoscopically to spring from the left ventricular band.

He declined tracheotomy, but the following morning was seized with great difficulty of breathing, and fell unconscious in a suffocative spasm, and, in spite of tracheotomy, could not be resuscitated. Microscopically, the tumour was found to be a round-celled sarcoma. The author thinks that in such cases laryngotomy is clearly indicated.

Norris Wolfenden.

SOLIS COHEN, J.—Treatment of Intralaryngeal Abscess from Necrosing Cartilage. *Med. News, December* 24, 1887.

On the principles of good surgery, such abscesses are best treated by splitting the larynx in the mid-line, removing the dead structures, and thoroughly scraping the parts down to healthy tissues. Drainage should then be provided for in case of continuance of suppuration, and asepsis adopted. Precautionary tracheotomy may be indicated, until the process of the disease has subsided, or to secure functional rest to the larynx. Such a plan is more judicious than waiting for discharge of carious particles, or attempts at endolaryngeal procedure, and many cases treated in this manner should be saved, which perish because tracheotomy is deferred until emergency calls for it, and the patient dies from septic poisoning from absorption of pus. Norris Wolfenden.

BARTHOLOW, R. (Phil.).—**Some Respiratory Neuroses.** *Medical News, December* 10, 1887.

The case is related of a young man, not yet 30, neurotic, in good general health, but suffering from paroxysms of sudden pain in or about the precordial region shooting through the chest in different directions, but specially the left neck and shoulder, and sometimes into the left arm. Respiration becomes gasping and shallow, cyanosis appears, the eyes protrude, the skin grows cold, and covered with clammy sweat, inhibition of the heart follows, its action then becomes rapid and feeble, and rhythm irregular; a deadly faintness comes on, and lately consciousness is lost for an instant. The paroxysms had commenced four or five years ago, and resemble angina pectoris. Twitchings of the facial muscles have latterly occurred, and the faintness has become complete unconsciousness. Pronounced disorders of digestion have now occurred, and just before each attack there is precordial oppression, eructations and nausea. The case has, with time, assumed more and more the character of epilepsy, such as Trousseau has described under the term "masked epilepsy," in which the first symptoms resemble angina pectoris. The author remarks, that very often we have examples of difficult respiration arising from reflex influences at a distance from the apparent seat of morbid action. Thus asthmatic trouble from renal disease, difficult breathing and hoarseness may be the first symptom of Bright's disease.

Norris Wolfenden.

ROSEN (Marburg). — **The After-treatment of Tracheotomy.** *Deutsch. Med. Wochenschr.*, 5, 1888.

The author recommends the surrounding of the canula with iodoform-

gauze. He calls it iodoform-tampon-canula. In this manner the canula will fill out the trachea and prevent the extension of diphtheria to the deeper parts. Of forty-five tracheotomies 53 per cent. were cured. (The same principle was published five years ago by the reporter as permanent tamponning of the trachea, but is not referred to by the author.) To cleanse the trachea from membrane, the author applies a ring-probe with good results. (The author also recommends tracheotomy for the cure of whooping-cough !) Michael.

LORD and KINTZING (Phil.)—**A Case of Spasmodic Asthma due to Aneurism.** *New York Med. Journ., February* 4, 1888.

THE obscure symptoms prevented the detection of the primary affection during life. The patient, who had suffered from irregular asthmatic attacks for three years, and was admitted into hospital with marked dyspnœa, died from asphyxia eight days after admission. At the autopsy the heart was found to be enlarged with ventricle hypertrophy, the heart bent upon its axis at the origin of the aorta, its long axis being in an exact right angle to the sternum, and the aortic valve at the same level as the apex ; the aortic and pulmonary valves fenestrated, the aorta dilated and atheromatous, the pulmonary artery constricted, and a large intra-pericardial aneurism involving the transverse and descending portions of the artery completely surrounding the trachea and œsophagus, and displacing them, nearly occluding the trachea. The sac was attached to the second, third, fourth, and fifth thoracic vertebræ, which it had eroded, and the pneumogastric nerve was pressed between the pericardium and the sac. The lungs were emphysematous. During life the pulmonary appears to have masked the cardiac condition. Norris Wolfenden.

BELL, JAMES (Montreal).—**Wound of the Internal Jugular Vein.** *Canada Medical and Surgical Journal*, 1887.

AN interesting account of a wound produced by a carpenter's inch-and-a-half chisel on which the patient had fallen, as the result of a ladder slipping. The common carotid artery was tied below the omohyoid muscle on the supposition that the bleeding was arterial. Pressure subsequently arrested the flow and recovery followed. On the following day a moderate amount of ptosis of the right eyelid was observed, as also contraction of the right pupil, and remained unchanged when the patient was last seen, some two or three months after the accident. After convalescence the reviewer made a laryngoscopic examination, and found complete paralysis of the right vocal cord. The sensation of the larynx was at the same time normal. G. W. Major.

KURZ, EDGAR (Florence).—**On Reflex Cough.** *Deutsch. Med. Wochenschr.*, 1888, *No.* 13.

COMMUNICATION of a case of spasmodic cough produced by a mucous polypus of the uterus. After removal of the neoplasm the cough was cured. Michael.

HAJIK (Wien).—**Diagnosis of Tubercular and Carcinomatous Perichondritis of the Larynx.** *Internat. Klin. Rundschau*, 1888. *No.* 9.

A CASE of infiltration of the epiglottis and the larynx, combined with, pulmonary affection and suppuration of the glands of the neck. The post-mortem examination showed that there was a carcinoma, but the history of the case very minutely related proves that it was impossible to say with certainty whether there was tuberculosis or cancer present. The reading of the original article will be of great interest. **Michael.**

NECK, &c.

TAYLOR, J. M. (Phil.).—**On the Early Recognition of Exophthalmic Goître.** *Polyclinic, April*, 1888.

THE author observes that the first symptoms are due to loss of nervous equilibrium. He speaks of a sallow, dark appearance of the skin, and greasy aspect as present in most of the cases he has seen. He has rarely seen muscular tremor, but has noticed tremulousness of the voice. The author refers to the cardiac symptoms, stating that the heart is rarely hypertrophied, but more commonly dilated; systolic bruits are often heard. The author regards the eye prominence as a late manifestation. He finds Von Graefe's sign commonly occurring before exophthalmos. The author relates notes of eight cases. One of these was sudden in onset. and there was bronzing of the skin. In three of these cases there was albuminuria, and in two, œdema of the lower extremities. The author's paper is well worth perusal. **Norris Wolfenden.**

LLOYD, J. H. (Phil.).—**Report of a Case of Rapidly Fatal Exophthalmic Goître.** *Polyclinic, April*, 1888.

THE author was summoned to a case (described as "cholera morbus"), a single woman aged 39, suffering for some hours with diarrhœa and obstinate vomiting. The whole abdominal aorta was throbbing intensely, and the heart's action was rapid. There was exophthalmos and an enlarged and soft thyroid gland. The patient's symptoms had first commenced six months before, with irritability of the stomach and prostration. The pulse increased in rapidity from 100 to 210 per minute, prostration was great, cyanosis of the hands and feet was observed and collapse was imminent. Several fainting spells occurred. The patient died at the end of the third day of her illness. This patient had had urticaria. A very imperfect autopsy was permitted. The left ventricle of the heart was a little dilated and hypertrophied. The case is interesting from its very acute character and rapidly fatal termination, for though the disease had been creeping on insidiously for some months, it had not attracted the attention of the patient or her friends till the fatal crisis occurred.

Norris Wolfenden.

WOLFENDEN, R. NORRIS (London).—**A New Point in the Diagnosis of Graves' Disease.** *Practitioner*, 1887.

THIS is a description of the method of estimating the resistance of the human body to the passage of an electric current, and in this paper the author shows how gravely the normal skin resistance is diminished in exophthalmic goître. Notes of twenty cases upon which the experiments were made are given by the author, and it is shown that in incipient forms of the disorder, the skin resistance is diminished to one-third of its normal standard, and in well developed cases it reaches as low as 300 ohms. In order to show that the observation is of value as a means of diagnosing early cases of Graves' disease, the author has made a number of observations (herein recorded) upon the electrical resistance in other nervous disorders, and it is shown that while in epilepsy, and to a lesser degree in hemiplegia, there is diminution of resistance, it is not so great or so constant in these and other nervous diseases as in Graves' disease. The author shows also that skin resistance is not diminished in ordinary goître, and this method therefore becomes of the greatest value in determining the nature of doubtful cases ; the treatment of the two classes of cases differing so widely. As improvement begins under treatment the skin resistance mounts more to the normal standard. To understand the author's experiments the paper should be read in the original.

Norris Wolfenden.

ROTH (Lengries).—Carcinoma of the Thyroid. *Munchener Med. Wochenschr, No.* 10, 1888.

A PATIENT, 55 years old, with carcinoma of the thyroid gland had, during this disease, delirium and attacks of vertigo. The author believes that these symptoms are caused by destruction of the tissue of the gland, and are analogous to cachexia strumipriva. **Michael.**

SHELSWELL, OSCAR B. (Mitcham).—**Myxœdema.** *Lancet, December* 31, 1887.

A LETTER to the Editors, in which the author directs attention to the greater prevalence of the disease amongst females as compared with males, and to the fact that the hæmorrhagic tendency appears to be a feature of the malady. **Hunter Mackenzie.**

WATT, A. (Lawrence, Mass.).—**Case of Myxœdema.** *Med. Rec., January* 28, 1887.

PATIENT was a woman, aged thirty-six, with neurotic history ; an uncle and brother both having been in insane asylums. She had suffered much from ill-treatment at the hands of her husband. The thyroid gland was normal, there was no albuminuria, the temperature was 97° Fahrenheit in the left axilla. She could scarcely walk without falling, and she had the usual signs of myxœdema. The disease had commenced six years before.

Norris Wolfenden.

FRASER, THOMAS R. (Edinburgh).—**The Dyspnœa of Bronchitis: its Causation and the Influence of Nitrites upon it.** *International Journal of the Medical Sciences, February*, 1888.

THIS forms the concluding portion of a paper dealing exhaustively with the subject. The author believes "that in bronchitis the rhonchi and sibili are frequently produced by (spasmodic) contractions of the bronchial muscles; that dyspnœa is produced by the impeded movement of air caused by the constrictions resulting from these contractions; and that both are removed by nitrites, because nitrites reduce the spasmodic contractions of the bronchial muscles." The paper is well worthy of careful perusal. **Hunter Mackenzie.**

GROSS, SAMUEL W. (Philadelphia).—**A Clinical Study of Carcinoma of the Breast, and its Treatment.** *International Journal of the Medical Sciences, March*, 1888.

The only point which concerns us here is that of metastasis. Out of 423 post-mortem inspections gathered from various sources, it was seen that the digestive, respiratory, osseous, and nervous systems are the seats of predilection, and that the lungs suffer rather more frequently than the liver. Of these 423 metastatic cases, secondary tumours were found in the

Bronchial glands	in 15	or	3·5	per cent.
Mediastinal glands	in 4	or	0·9	,,
Lung and pleura	in 38	or	8·9	,,
Pleura	in 178	or	42·0	,,
Lung	in 175	or	41·0	,,
Thyroid gland	in 8	or	1·8	,,
Œsophagus	in 1	or	0·2	,,

No mention is made of any metastatic deposits in the larynx, trachea, or nose. **Hunter Mackenzie.**

REPORTS OF SOCIETIES.

Medico-Chirurgical Society of Edinburgh.

July 6th and 20th, 1887.

1.—DR. JAMES RITCHIE narrated the history of three cases of gastro-intestinal disturbance arising from the tainting of the atmosphere of rooms by dead mice. In each case sore throat was present, along with sickness, diarrhœa, and constitutional debility.

2.—W. ALLAN JAMEISON.—*Scarlet Fever.*—In opening a debate on this subject Dr. Jameison made some observations of interest to the laryngologist. He described naso-pharyngeal purulent catarrh as being a troublesome complication, which keeps up the temperature and prolongs recovery. Secondary sore throa

is a parenchymatous tonsillitis, which may terminate in abscess, or may disappear by absorption; it is also a cause of a rise in temperature. The enlargement of the cervical glands may be single or multiple. When single and implicating the parotid or salivary gland, it may end in suppuration; when multiple, involution is the rule. This enlargement seems to be of septic origin, and to be due to absorption from the inflamed throat in the commencement of the disease. A rise in temperature is characteristic of the development of glandular enlargement.

In regard to diagnosis, mention is made of the fact that rötheln is frequently mistaken for scarlet fever. The author thinks that the condition and behaviour of the tongue afford the surest clue to diagnosis. "In rötheln the tongue is thickly coated over the larger part of its area with a brownish fur, the sides alone being natural in appearance. When it cleans this fur melts away, and leaves a normal surface. In scarlet fever the tongue on the second day is pretty thickly overlaid with white soddened epidermis which, separating from before backwards, discloses a surface resembling raw beef, on which the normal epithelial covering is replaced rather slowly."

For treatment of the sore throat of the disease, the author affirms that a saturated solution of boro-glyceride in glycerine is the best, along with weak mouth washes of permanganate of potash. For the glandular enlargement, enveloping the neck in thick folds of cotton wool, painting with iodine, or the application of an iodide of potassium ointment made with lanoline are recommended. Naso-pharyngeal catarrh, occurring as it did solely in children, was difficult to treat; this consisted chiefly in the administration of quinine, and syringing the nose with boracic lotion.

3.—J. MACKENZIE JOHNSTON, made some remarks upon a paper by Mr. Mac-Bride on adenoid tissue at the base of the tongue, etc., which has been already noted in our columns. *(Journal of Laryngology*, etc., Vol. i., p. 411.*)*

Congress of Physicians in Hamburg.

Meeting, February 21, 1887.

LAUENSTEIN demonstrated a patient in whom he had extirpated the soft palate after preliminary tracheotomy. The patient was cured but had nasal speech. This could be improved by closing the nose. Dr. Lauenstein recommends the application of a pince-nez which should close the nose.

THOST showed a specimen of the larynx extirpated by Stoerk for carcinoma (the well-known case).

SCHEDE believed that such a benign process is very rare. He did not believe that benign neoplasms can be transformed into malignant by intra-laryngeal operations.

BÜLAU agreed with this view, and also E. Fränkel. **Michael.**

Meeting, March 20, 1888.

M. ALSBERG demonstrated a patient on whom he had performed external œsophagotomy for carcinoma of the œsophagus with impermeable stricture. The tumour had also perforated the larynx. A growth could be seen occupying the posterior wall, and also œdema of the arytenoid cartilages. The patient, before the operation, was in a high state of inanition, but now, since taking her food by the fistula, she is much better. She is content with her condition, and declines a medical operation which has little chance of success. **Michael.**

Berlin Medical Society.

Meeting, March 21, 1888.

GUTTMANN.—*On the Reflex Relation between the Corneal Branches of the Trigeminus and the Respiration.*

IN a case of atropine intoxication every touch of the cornea produced inhibition of the respiration lasting some seconds. The experiment was sometimes repeated with the same effect. This reflex relation has not yet been published.

HIRSCHBERG had seen inhibition of respiration during cauterisation of the eyelids. **Michael.**

Congress for Internal Medicine in Berlin

Meeting, February 6, 1888.

HEYMANN (Paul) showed a syphilitic and aphonic patient. The laryngoscope showed that the left vocal cord did not approach the middle line at its mid part during phonation; the arytenoid cartilage came normally to the middle line. During inspiration the larynx had a normal appearance. On the left vocal band was a little tumour. The author believed that there was an isolated paralysis of the left musculus crico-arytenoideus lateralis. This affection is very rare; such cases have only been communicated by Morell Mackenzie and Nikolas Duranty. **Michael.**

Congress of Physicians at Riga.

Meeting, November 4, 1888.

BERGMANN.—*On Primary Erysipelas of the Larynx. Communication of two Cases.*

CHARACTERISTIC of the affection in its rapid progress, and the presence of specific bacilli. The case was tracheotomized. **Michael.**

Congress of Physicians, Erlangen.

Meeting, February 27, 1888.

PROF. HEINCKE showed two patients with stricture of the œsophagus. One of them had cicatricial stenosis, which could only be passed after œsophagotomy. The other had a carcinoma of the cardiac end of the œsophagus. Gastrotomy should be performed. **Michael.**

Society of Swedish Physicians, Stockhol .

Meeting, January 17, 1888.

DR. SVENSSON related two cases of glossodynia (glossalgia, ulceration imaginaire de la langue) in two women, aged about twenty and fifty, without any other nervous or hysterical symptoms. The complaint had become totally unbearable for both patients on account of the constant feeling of soreness, now and then interrupted by neuralgic pains. After having tried internal remedies, applications of caustics, injections of morphia, cocaine, massage, cauterisations with Paquelin's thermocautery, etc., the speaker has tried on the young woman resection of the one lingual nerve, but everything was of little or no effect whatever, and only injections of iodine dissolved in spirit (1—10) had relieved the last patient, while the other one had given up the treatment. There was nothing abnormal whatever to be discovered by examination of the tongue.

DR. SETTERBLAD recommended strongly the use of massage in minor cases.

Holger Mygind.

Toronto Medical Society.

Meeting, January 12, 1888.

DR. GRAHAM.—*Graves' Disease. Fatal Case.*

THE patient, male, aged forty-four years, developed enlargement of the thyroid gland twelve years previously. Two months previous to his death dyspnœa commenced, accompanied by emaciation and prominence of the eye-balls. The heart's action was increased, and a systolic bruit could be heard on a line with the third costal cartilage and down the sternum, but not at the apex. The patient was suddenly seized with violent vomiting and died in a few days.

G. W. Major.

REVIEWS.

GOTTSTEIN (Breslau).—**Diseases of the Larynx, including Laryngoscopy and Local Therapeutics.** *Second Edition. Wien und Leipzig.*

THE author is one of the most experienced German laryngologists, and is well known by his numerous essays and technical inventions. The first edition of his book (1883) has had a great success, and has been translated into English, French, and Russian. The recommendation of the book is the concise form in which all that is necessary is said relating to each disease without prolixity. The book is so well known to all specialists that it will only be necessary to mention the improvements and additions in this second edition. All the latest developments of the science have been dealt with, and each section brought down to date. Descriptions have been added of the electric laryngoscope, the tube-forceps of Gottstein, intubation of O'Dwyer, use of cocaine, parabolic iron reflector of Michael, the views of Virchow on pachydermia laryngis, the successful case of extirpation of carcinoma laryngis *per vias naturales*, by B. Fränkel, the new cases of total extirpation, the latest works on abductor paralyses, the angioneurotic œdema of Strübing, the new methods of treating laryngeal phthisis with lactic acid, curetteing and tracheotomy, primary erysipelas of the larynx, and its relation to the specific micro-parasites. The chapters on affections consecutive to the acute infectious diseases are treated with special relation to the important treatises of Löri. Newly added and of great interest are two chapters on laryngeal affections in relation to diseases of the brain and the spinal cord. Both theory and the facts are communicated in a very concise and clear manner. The book is to be recommended both to laryngologists and general practitioners.

BULLAR, M. and J. F.—Recipes for Fluid Foods. H. K. Lewis, *London*, 1887.

THIS is a little book of only twenty pages, containing practical instruction for the making of foods suitable for a sick person. The authors go upon the scientific principle that a diet "in which the ordinary articles of food are rendered drinkable is much more natural, and, therefore, probably more wholesome than one in which beef-tea, extract of meat, or soup, is substituted for meat and fresh vegetables." In using the recipes contained in this little book, a person may be able to take all the constituents of an ordinary meal in a fluid form. We have no doubt that the little book will prove of great value to those in charge of the sick.

NOTES.

Dr. Scanes Spicer has been appointed to the charge of the Throat Department of St. Mary's Hospital in London.

The Post Graduate Classes of Laryngology and Rhinology, the first session of which has been so successful, at the Throat Hospital, Golden Square, will be resumed on May 14th.

Honours to Laryngologists.—Dr. Hermann Krause has been nominated to a professorship in the University of Berlin, in recognition of his services to the German Emperor. Sir Morell Mackenzie has been rewarded by His Majesty with the Grand Cross of the Hohenzollern Order, and with the Star of the same order. To Mr. Mark Hovell, the second class of the Kronen Order has been awarded.

American Laryngological Association. — *Preliminary Notice.* — The Tenth Annual Convention of the American Laryngological Association will be held in Washington, D. C., September 18th, 19th, and 20th, 1888, conjointly with the First Congress of American Physicians and Surgeons. In addition to the General Sessions of the Congress, a programme of which is herewith enclosed, the regular exercises of the American Laryngological Association will be conducted as has been usual heretofore. For the information of those who may be interested, a programme will be issued, containing the names of authors and titles of papers to be read and such other announcements as may be desirable. The Association extends a cordial invitation to all who may be interested in the study of laryngology to attend this Congress, which, as its tenth anniversary, promises to be of unusual interest and importance. — D. BRYSON DELAVAN, *Secretary*, No. 1, East 33rd Street, New York, U.S.A.

Card.—I think it due to my American colleagues to state that, owing to serious trouble with my eyes for some time past, I have been unable to give that attention to their publications which their number and importance demands. As it has, therefore, become necessary, for the present, to procure assistance in editing the American reports, I have secured for that purpose the services of my former clinical assistant, Dr. T. Morris Murray, of Washington. As I am naturally desirous that the work of my *confrères* shall receive its due share of review and editorial comment, and as many of the periodicals in which the irarticles appear are inaccessible to me, authors would confer a favour upon me by forwarding to my address, as soon after publication as possible, reprints of the papers or copies of the journals in which they appear. By so doing, they will also insure a more speedy and certain review of their work.—JOHN N. MACKENZIE, 605, North Charles-street, Baltimore.

London : Paraon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Article, p. 223.—MAVO COLLIER: The Epiglottis: Its Attachments and Relations to Surrounding Structures.

New Instruments and Therapeutics, p. 224.—CARPENTER: Lamp for Examination. POTTER: Nasal Scissors. VEO: Address on Therapeutics of Uric Acid Diathesis. PARKER: Incompatibility in Pharmacy. TREVES: Treatment of Carotid Hæmorrhage. COCHRANE: Ergotism in Hæmoptysis. ALLEN STURGE: Antipyrin; a warning. EDMUNDS: Cocaine. POTTER: Curious Effect of Cocaine. MOREAU AND COCHEZ: Hydrofluoric Acid for Diseases of Respiratory Passages. THORNER: Salol. WEILL: Carbonic Acid for Dyspnœa. SCHUSTER: Bergeon's Clysmata of Carbonic Acid, etc., in Diseases of Lungs. SPENCER: Antiseptic Treatment of Phthisis. WAGNER: Colorado Springs and Davos Platz. THOMSON: Winter Climate of Florence.

Diphtheria, p. 228.—BRISTOWE: Diphtheritic Paralysis. LEGROUX: Diphtheria and Creosote. MOHAMMED: Treatment of Diphtheria. BEAUPÈRE: Chloroform Anæsthesia in Tracheotomy.

Nose and Naso-Pharynx, p. 231.—LERMOYEZ: Hay Asthma. COUPARD: Foreign Bodies in Right Nostril. POTTER: Tuberculosis of Nose, Mouth, and Pharynx. HINKEL: Irregularities of Septum Narium. SEILER: Ecchondroses of Septum Narium. GRADLE: Ocular Symptoms in Nasal Disease. SCHMIDT: Bilateral Amaurosis. CORIVEAUD: Choreiform Convulsions of Reflex Origin. STONHAM: Naso-Pharyngeal Polypus. FONTAN: Temporary Maxillo-malar Resection. HERMET: Cauterization of Posterior Region of the Turbinated Bodies. POESCHEL: Diseases of the Naso-pharynx.

Mouth, Tonsils, Pharynx, &c., p. 234.—BROCA: Hare-lip. LLOYD: Composite Odontome of the Upper Jaw. QUENU: Maxillary Fistula. HADDEN: Suppression of the Salivary and Buccal Secretions. ROWLANDS: Permanent Suppression of the Salivary Secretion. BUXTON: Ibid. COOPER: Communicability of Syphilis through Saliva. PHILIP: Contribution towards the Etiology of Phthisis. VERCHÈRE: Treatment of Ranula. GUINARD: Congenital Ranula. WHITEHEAD: Excision of the Tongue. GILLOT: Ampullary Dilatations of the Tongue. MAURIAC: Tertiary Syphilitic Glossopathies. FERRIER: Paralysis of 5th Cranial Nerve. HILLABY: Treatment of Tonsillitis. POTTER: Galvano-Cautery in Treatment of Enlarged Tonsils. VILLAR: Lymphadenoma of the Tonsils. TISSIER: Follicular Amygdalitis. CARPENTER: Sore Throat Affections. WEIL: Chronic Pharyngitis. HAGER: Infectious Phlegmon of Pharynx. BARUCK: Ibid. M.D.: Pharyngeal Syphilis. HOUTANG: Softening Gumma of the Pharynx. MOURE: Mycosis of the Pharynx. BURKHARDT: Retro-Pharyngeal Abscesses. MELTZER: Case of Dysphagia. TERRILLON: Stricture of the Œsophagus. AUDRY: Ibid.

Larynx, p. 242.—SEILER: Physiology of the Voice and Speech. BRACHET and COUPARD: Hygiene of the Vocal Organs. BRUGELMANN: Asthma. SEIFFERT and HOFFA: Congenital Membranous Formation in the Larynx. LENICKE: Cicatricial Laryngo-Stenoses. KOCH: Phonetic Spasm of the Glottis. REMAK: Traumatic Paralysis of the Sympathetic Nerves. SEMON: Vulnerability of the Fibres of the Recurrent Nerve. ROSENBACH: Ibid. FRÄNKEL: Remarks on Remak's case. OKELL: Tracheotomy in Tubercular Laryngitis. MACKENZIE: Thyrotomy for Growths of the Larynx. SMITH: Removal of Foreign Bodies from Air-Passages. L'ABBÉ: Foreign Body in the Larynx. DEMONS: Extirpation of the Larynx. DU CAZAL: Wounds of the Larynx. LUC: Tracheal Ozæna.

Neck, &c., p. 246.—PETIT: Gaseous Tumours of the Neck. SEGOND: Cystic Goître. GAUTHIER: Thyroidean Cachexia. VIERORDT: Goître and Laryngitis Hypoglottica. BALLET: Exophthalmic Goître. HAW: Hæmorrhage in Myxœdema. DAVIES: Ibid. JALLAND: Tumours of Left Parotid. TILLAUX: Lipoma of the Neck. WALTER: Report of the Polyclinic in Munich.

Congress Meeting, p. 248.—Congress of Physicians in Vienna.

Reports of Societies, p. 249.—Northumberland and Durham Medical Society; Pathological Society of London; Sunderland and North Durham Medical Society; British Medical Association: Nova Scotia Branch; Royal Medical and Chirurgical Society; Medical Society of London; Royal Academy of Medicine in Ireland; Clinical Society of Manchester; Cambridge Medical Society.

Tabloid Triturates { The Latest Advance.

LONDON.] JUNE. [1888.

"Tabloids" of Triturated Drugs.

Safer, Pleasanter, and more Efficient and Convenient Medication for Infants, the Fastidious and Idiosyncratic.

An Innovation.

Brunton points out that the introduction of the method of giving small doses at frequent intervals has "*the very great advantage that the desired effect can be produced with greater certainty and with less risk of an over-dose being taken.*"

As fulfilling every requirement possible as regards a safer, pleasanter, more accurate and convenient mode of administering medicines to infants as well as others, and as essentially obviating the disagreeable effects of drugs, the Compressed "Tabloid Triturates" are now introduced.

What are "Tabloid" Triturates?

The Compressed "Tabloid" Triturates are "intimate mixtures of substances with sugar of milk." In no way are they allied to the sugar of milk globules or pellets, dependent so largely upon chance for the absorption of the medicaments poured down the side of the bottle. The following directions are those given in the Pharmacopœia, U.S., for the preparation of Triturates: "Take of the substance ten parts, sugar of milk in moderately fine powder ninety parts, to make one hundred parts; weigh the substance and the sugar of milk separately; then place the substance, previously reduced if necessary to a moderately fine powder, into a mortar, add about an equal bulk of sugar of milk, mix well by means of a spatula, and triturate them thoroughly together. Add fresh portions of the sugar of milk from time to time, until the whole is added, and continue the trituration until the substance is intimately mixed with the sugar of milk and finely comminuted."

Resumé of Advantages

Of "Tabloid" Triturates:—*

1. The Tabloid Triturates are made with the pure drug and sugar of milk.

2. The process of trituration employed so finely subdivides and separates the mass of medicament that this is said to be more active than would the same quantity given in the ordinary way.

3. They contain each a very small dose, so that by giving one at a time—they may be repeated often—the taste of the drug is hardly, if at all perceived.

4. Being made with sugar of milk, one of them (if not taken whole) added to a little milk or other fluid, is at once "broken up" and distributed throughout the liquid.

5. Pulverulent substances, like calomel, are by this means especially distributed well, and for the moment suspended throughout the fluid.

6. They do not roll about the mouth, or stick in the throat, like pills. A great advantage.

7. Being very small, and not globular, they are easy to swallow.

8. They do not harden and become insoluble with time, nor do they crumble, like pills.

9. They are the most convenient form of medicine for infants and fastidious patients, as such a small quantity may be taken at a time that the taste becomes insignificant.

10. *They afford the advantages derivable from the administration of small doses repeated often, which are,—1. That if the drug be given in but little liquid, the absorbent power of the mucous membrane of the mouth and gullet are called repeatedly into requisition. 2. That if given on an empty stomach (as is generally desirable) unpleasant symptoms are avoided. 3. In case of idiosyncrasy, the dose can be stopped before large amounts have been given. 4. Administered in this way drugs are better tolerated than is otherwise the case.*

11. A greater effect is alleged to be obtainable by this method from a small quantity of medicine than is possible by the usual plan.

12. In some cases, "Tabloid" Triturates are repeated as often as every five or ten minutes, and it is surprising *how soon a very small dose of medicine repeated often amounts to a very large quantity.*

13. If taken whole, one of the "Tabloid" Triturates dissolves and falls to pieces in the stomach at once, and is never voided unchanged.

14. They afford accuracy of dose, without the trouble and annoyance of weighing or measuring.

15. They can be taken at any time and in any place, even when the patient is following his ordinary avocation.

16. They are only a few lines in thickness, and about quarter the circumference of a lead-pencil.

* A very interesting and instructive essay on this subject by William Murrell, M.D., F.R.C.P., appeared in the Practitioner for Dec., 1887.

LIST OF TABLOID TRITURATES.

Price to the medical profession, 8*d.* per bottle of 100 of the following Tabloid Triturates. Retail price, 1*s.*

Aconite Tinct.	1 min.
Arsenious Acid	1-100 and 1-50 gr.
Belladonna Tinct.	1 min.
Calcium Sulphide	1-10 gr.
Capsicum Tinct.	1 min.
Digitalis Tinct.	1 min.
Hydrarg. Perchlor.	1-100 gr.
Hydrarg. Cum Creta	1-3 gr.
Hydrarg. Subchlor. (Calomel)	1-10 gr.
Hyoscyamus Tinct.	1 min.
Nux Vomica Tinct.	1 min.
Tinct. Camph. Co. (Paregoric).	2 min.

Price to the medical profession, 8*d.* per bottle of 50 of the following Tabloid Triturates. Retail price, 1*s.*

Anti-Constipation.	Aloin	1-5 gr.
	Strych.	1-60 gr
	Belladon. Ex.	1-8 gr.
	Ipecac.	1-16 gr.
Apomorphine Mur.		1-50 gr.
Atropin Sulph.		1-100 gr.
Digitalin		1-100 gr.
Euonymin Resin		1-8 gr.
Hydrarg. Iod. Rub.		1-20 gr.
Hydrarg. Iod. Vir.		1-8 gr
Morphine Sulph.	1-20 and	1-8 gr.
Opium Tinct. (Laudanum)		2 min.
Pilocarpin. Mur.		1-20 gr.
Podophyllin Resin		1-4 gr.
Santonin		1-2 gr.
Strophanthus Tinct.		2 min.

Waistcoat Pocket Cases, containing eleven tubes of 25 tabloids each (any selection), supplied to the medical profession at 5*s.* post free.

THE
JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. JUNE, 1888. No. 6.

The Editors invite original contributions.

Fifty Reprints will be supplied to each author gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

THE EPIGLOTTIS: ITS ATTACHMENTS AND RELATIONS TO SURROUNDING STRUCTURES.

By MAYO COLLIER, M.B., M.S. Lond., F.R.C.S. Eng.

As a teacher of anatomy now, for several years, when endeavouring to explain and simplify the description of the larynx and adjoining parts, I have always experienced some difficulty when following the description in the books. I have endeavoured to reconcile the actual state of things with that description. My difficulties at once beset me when the region of the epiglottis was approached, and whilst following almost word for word the description as found in the books, I was conscious that the arrangements so described were not found in nature.

The epiglottis may be looked upon as a fence or partition, moored by various bands between the oral and pharyngo-oral cavities.

The epiglottis is attached by its lower pointed extremity to the angle between the two alæ of the thyroid cartilage. It stands on this pointed extremity as a cone resting on its apex.

The epiglottis is formed of a piece of fibro-elastic cartilage, with thick, sharply-cut edges; these edges curve backwards slightly, and are embraced by the mucous membrane on the inner and outer aspects of the aryteno-epiglottidean folds.

The mucous membrane on the inner aspect of the aryteno-epiglottidean fold passes directly on to the posterior surface of the epiglottis over its free border, which is quite evident from behind; on the outer side of the aryteno-epiglottidean fold, the mucous membrane does not come in contact with the anterior edge of the free border, but passes upwards and outwards at some distance on to what will presently be described as the hyo-epiglottic membrane. The whole anterior surface of the epiglottis rests upon, and is, as it were, glued to, a membrane almost entirely composed of elastic tissue, thin comparatively, but very strong.

This membrane is attached below to the whole length of the hyoid bone from tip of great cornu to great cornu.

Above, it is co-extensive with the epiglottis in the middle, and passes off on each side to a little above the great cornu of the hyoid bone, forming two prominent folds at present most incorrectly described as the lateral glosso-epiglottic ligaments.

I say most incorrectly described, because the folds have absolutely no connection, except from the continuity of the mucous membrane, with any portion of the tongue. The unattached portion of this membrane, *i.e.*, that portion above the great cornu of the hyoid bone, passes upward and forward, and spreading out, lines the fossa for the tonsil. The anterior aspect of this fold is covered by mucous membrane, continuous with that on the tongue.

The posterior aspect is covered with mucous membrane, continuous with that on the outer aspect of the aryteno-epiglottidean fold.

Below, the posterior aspect of the hyo-epiglottic membrane forms the anterior boundary of a pyramidal space, through which the superior laryngeal artery and nerve pass to their destination. The base of this space is formed by the usually-described thyro-hyoid membrane, which, as I trust I shall presently show, does not exist. I have never been able to find any fibro-elastic membrane, as described by the books, between the hyoid bone and the thyroid cartilage. A thin fascia lining the under aspect of the thyro-hyoid muscle, and covering over a quantity of cellular tissue and fat in the hyo-epiglottic space, is all that is apparent. This fascia is co-extensive with and intimately attached to the hyoid origin of the thyro-hyoid muscle ; a well-marked interval existing between the two portions on opposite sides.

A ligament, described as the lateral thyro-hyoid ligament, resting upon, and external to, the middle constrictor of the pharynx, is a well-marked and important structure, rounded cord-like, $\frac{3}{4}$ of an inch in length, and extends from the tip of the great cornu of the hyoid bone to the tip of the upper cornu of the thyroid cartilage.

NEW INSTRUMENTS AND THERAPEUTICS.

CARPENTER, G. A. (London).—**Lamp for Laryngoscopic and Ophthalmoscopic Examination.** *Lancet, January* 14, 1888.

DESCRIPTION of a lamp for the double purpose, and which can also be converted into an ordinary reading lamp. It is made by Messrs. Down Brothers, St. Thomas's Street, London. **Hunter Mackenzie.**

POTTER, F. H. (Buffalo).—**A Nasal Scissors.** *Buffalo Med. and Surg. Journal, March*, 1888.

BLADES, $1\frac{5}{8}$ inches long, strongly made, and with serrated edges. Made by Tiemann & Co., New York. **John N. Mackenzie.**

YEO, BURNEY (London).—**An Address on the Therapeutics of the Uric Acid Diathesis.** *British Medical Journal, Jan.* 7, 1888.

AMONGST the principal morbid conditions dependent on or associated with the uric acid diathesis, are mentioned dysphagia from œsophageal spasm, laryngo-pharyngeal catarrh, bronchitis, and asthma.

Hunter Mackenzie.

PARKER, R. H. (London). — **Incompatibility in Pharmacy.** *Lancet, January* 7, 1888.

AS the drugs mentioned therein are frequently used in laryngological practice, it is deemed appropriate to reproduce the following note to the Editors of the *Lancet*:—

"Several prescriptions have lately come under my notice in which occurs a mixture of chlorate of potash and syrup of iodide of iron. This seems a not unreasonable combination, and its incompatibility does not suggest itself, nor will it be found on reference to ordinary text-books. As, however, a case has recently been reported in which death resulted from the administration of such a mixture, I think it desirable that attention should be drawn to the fact that chlorate of potash liberates the whole of the iodine from iodide of iron, and if at all concentrated, the solution soon becomes saturated, and crystals of iodine are deposited after a few hours. Heat favours the reaction, and the process, which may be slow in the medicine bottle, would be much more rapid in the stomach, where the development of nascent iodine might produce symptoms of gastric irritation which were neither expected nor desirable." **Hunter Mackenzie.**

TREVES, FREDERICK (London).—**The Treatment of Carotid Hæmorrhage.** *Lancet, January* 21, 1888.

THE author is of opinion that the ligature of main arteries for the arrest of bleeding in distant parts is often somewhat blindly advised, and possibly too frequently carried out. To stop hæmorrhage from arteries of medium or small size, it is often only necessary that the local circulation should be temporarily slowed or stopped.

In dealing with limbs, this may be brought about by compression, *e.g.*, by an elastic tourniquet. In the neck, however, pressure cannot be so equally or successfully applied, but the vessel (carotid) may be very readily occluded for a sufficient length of time by exposing it in the usual way, and passing round it a thick piece of soft catgut. This is tied in a very loose loop ; by pulling upon this loop the circulation through the vessel is at once arrested, but is restored when the tension upon the loop is relaxed.

The author recorded four cases of hæmorrhage successfully treated by this method of temporarily occluding the carotid artery.

Hunter Mackenzie.

COCHRANE, JOHN (Skye).—**Ergotium in a Case of Hæmoptysis.** *Lancet, January* 21, 1888.

IN the case of a middle-aged woman with hæmoptysis, the subcutaneous injection of $\frac{1}{150}$ gr. was followed by a sudden accession of syncope, from which the patient slowly recovered. At the same time the drug was most successful in controlling the hæmorrhage.

The author is uncertain whether the alarming syncopal attack was due to fear, or to the action of the drug, though he inclines to favour the latter.

[We think the effect was due to the contraction of the cerebral capillaries from the action of the drug.] **Hunter Mackenzie.**

STURGE, ALLEN W. (London).—**Idiosyncrasy with regard to Antipyrin: a Warning.** *British Medical Journal, February* 4, 1888.

IN this case, after administration of five grains of antipyrin, the patient was seized with violent sneezing (which continued for about twenty minutes), along with a discharge of mucus from the nose, difficulty of breathing, and a feeling of suffocation. Shortly afterwards a violent cough came on, and large quantities of mucus were expectorated. The discharge from the nose continued for four or five hours. Urticaria developed on the thighs and abdomen. Patient recovered, with considerable improvement in regard to the migraine (with sickness), for which the drug was administered. **Hunter Mackenzie.**

EDMUNDS, WALTER (London).—**Experience in the Use of Cocaine.** *Lancet, January* 7, 1888.

THE author recommends that nothing stronger than a 5 per cent. solution ought to be used for subcutaneous injection, otherwise certain constitutional symptoms may be induced. **Hunter Mackenzie.**

POTTER, F. H. (Buffalo).—**A Curious Effect of Cocaine.** *Buffalo Med. and Surg. Journal, December*, 1887.

RELATION (in detail) of a case in which the application of cocaine to the nasal mucous membrane produced invariably a strong desire to have a movement of the bowels. Various central experiments were undertaken to test the accuracy of the observation.

[That irritation of the nasal membrane may provoke a desire to go to stool has been known for many years. In the early part of the last century, Bagliri (*Op. Omnia. Med. Pract.*, Lugd. 1714, spec. lib. I., cap. x., p. 342 *et seq.*) called attention to the fact, which has been since apparently forgotten, and Dr. Potter's observation is another interesting illustration of this curious relationship.] **John N. Mackenzie.**

MOREAU AND COCHEZ.—**Effect of Hydrofluoric Acid in the Treatment of Diseases of the Respiratory Passages.** *Congrès de Oran, March*, 1888.

THE authors had administered hydrofluoric acid to sixty patients by the inhalatory method of Garcin and Seiler. The results obtained seemed

to them fairly encouraging, and, if the medication is not a sovereign remedy, it is useful, and has never appeared to be harmful. Hydrofluoric acid appears to increase the appetite, to modify the nature of the bronchial secretion, and probably to destroy the microbes and their infectious productions in this secretion, if not in the pulmonary tissues itself.

Joal.

THORNER, MAX (Cincinnati).—**Salol: with Report on the Use of Salol in Affections of the Throat, Ear, and Eye.** *Cincinnati Lancet-Clinic, December* 10, 1887.

A GOOD review of the literature of salol. The author has used it with advantage in acute pharyngitis (mainly rheumatic in origin) in doses of 10-15 grains three times a day. After two doses the patients were able to swallow, and the following day nothing but congestion was present. He has also used it with success in follicular tonsillitis, quinsy, and torticollis rheumatica. In a 6 per cent. alcoholic solution, Thorner has used salol in stomatitis mercurialis, syphilis of the pharynx, and other affections, but failed to find any advantage over other local applications previously used.

John N. Mackenzie.

WEILL, E.—Carbonic Acid in Treatment of Certain Forms of Dyspnœa. *Acad. des Sciences, February* 27, 1888.

TUBERCULAR patients, mostly suffering from laryngitis and advanced pulmonary lesions, have inhaled carbonic acid by means of Limousin's apparatus. The "séances," repeated once or twice a day, lasted from two to five minutes, and the dose of carbonic acid varied from 2-4 litres at each inhalation. If the carbonic acid was inhaled at the moment of a dyspnœic paroxysm, the attack was cut short to a certain extent, and replaced by a feeling of comfort. If the inhalation was given between the attacks, it was observed that the first effect was freer respiration, and the succeeding paroxysms then became less frequent and less intense.

Joal.

SCHUSTER (Aachen).—**Bergeon's Clysmata of Carbonic Acid and Sulphuretted Hydrogen in Diseases of the Lungs and Larynx.** *Deutsch. Med. Wochenschr.*, No. 15, 1888.

A REPORT of the application of this treatment in three cases, phthisis laryngis, whooping-cough, and emphysema, with good results.

Michael.

SPENCER, W. H. (Bristol).—**Cases Illustrating the Antiseptic and Antipyretic Treatment of Phthisis.**

THE treatment recommended is iodoform, given frequently and continuously for long periods, continuous inhalation of oil of eucalyptus, or other antiseptic, with the addition of quinine as an antipyretic.

(Iodoform is not a germicide. *See* Jeffries on "Anti-Bacterial Action of Iodoform," *International Journal of the Medical Sciences*, January, 1888.)

Hunter Mackenzie.

WAGNER, CLINTON (New York).—**Colorado Springs and Davos Platz, as Winter Resorts, Compared.** *New York Med. Record, October* 29, 1887.

A VERY valuable article based on personal observation, and a reliable guide to an often perplexing subject. Among other things of interest, Wagner thinks that further experience is wanting before condemning, as is usually done, high altitudes for the relief or cure of laryngeal tuberculosis. While at Colorado Springs, he saw many cases of pulmonary tuberculosis that had recovered, and others advancing toward recovery. Although his experience is limited, he believes that cases of laryngeal phthisis may safely be permitted to remain at high altitude resorts, *provided* improvement in the pulmonary trouble and general condition has already taken place. Colorado Springs and Davos are described in detail by the author. **John N. Mackenzie.**

THOMSON, ST. CLAIR (Florence).—**Winter Climate of Florence and Genoa.** *British Medical Journal, January* 14, 1888.

A NOTE recommendatory of Florence as a residence for asthmatics. The cold is very sharp in the winter, and as at all times the difference between sun and shade temperatures is considerable, it is not suited to most phthisical patients until spring. The dryness of the climate suits people of a gouty disposition. Genoa is colder, bleaker, and has much less sunshine than Florence. **Hunter Mackenzie.**

DIPHTHERIA.

BRISTOWE, J. S. (London).—**An Address on Diphtheritic and Related Forms of Paralysis.** *British Medical Journal, February* 4, 1888.

THIS address consists mainly in the narration of a series of cases, with relative remarks:—

Case I.—This was the case of a clergyman, who in June, 1879, suffered from sore throat (doubtless diphtheritic), followed in October by paralysis. "The nervous symptoms tended to be symmetrical, and spread from region to region, affecting the hands and legs in larger proportion than other parts. The paralysis of the extremities was attended with the so-called reaction of degeneration, and the anæsthesia of the feet, with a sense of soreness and pain. In addition also to defective accommodation and to weakness of the soft palate, there was anæsthesia of certain circumscribed tracts, occupying the middle line of the body, including, amongst others, the epiglottis, and parts about the rima glottides, and some paralytic failure of the muscles of the larynx, which contributed to

render straining difficult, and of the muscles of respiration, causing dyspnœa." The patient recovered in the following March.

Case II.—This case illustrates that the tendon-reflexes may disappear in diphtheritic paralysis, and is one of the first examples observed of this now well-recognised fact. The author directs attention to the circumstance noted by Drs. Herringham, Money, and Barlow, that though the tendon-reflexes do disappear in those cases, their actual disappearance is generally, if not always, preceded by a period of several days' duration, in which they present excessive briskness.

Case III.—The interest in this case lies in the fact "that not only was there this excess of tendon-reflex (already referred to as preceding abolition), but it was maintained practically throughout the whole of the patient's illness, and was only replaced by its abolition after paralysis and numbness had disappeared, and the patient seemed to be in good health."

Case IV.—This case shows that while, as a general rule, the paralytic phenomena of diphtheria are remarkable for their tendency to symmetry of distribution, the symmetry is not absolute, and local paralyses of single nerves may be met with. In addition to various symmetrical paralyses of the limbs, etc., the patient presented well-marked general paralysis of *left* portio dura. He completely recovered in a few weeks.

Case V.—In the record of this case is embraced a table containing an exhaustive account of the electrical condition of the paralysed muscles by Dr. Kilner. The muscles generally presented the reactions of degeneration.

In commenting on the above cases, which are very carefully recorded, the author states his opinion that while many of the phenomena can be explained on the theory that they are due to spreading neuritis, others (such as the sensory affections along the middle line, the early increase of the knee-jerk, and nystagmus) seem rather to point to some spreading central lesion—a sort of wave of slight inflammatory mischief, which extends not only through the medulla oblongata and cord, but also along the nerve trunks.

The author then goes on to speak of some nervous diseases which may closely simulate diphtheritic paralysis. He remarks that it is well to remember that paralysis often follows so mild an attack of acute diphtheria, that the patient may remember nothing about his sore-throat, and that paralytic symptoms may in tabes be of almost sudden onset—The paralysis of tabes ought not to be confounded with that of diphtheria.

It is, however, more in the cases of multiple (non-diphthertic) neuritis especially in alcoholics, that mistakes in diagnosis are apt to occur.

Case VI. This case, which might reasonably have been taken for diphtheria, was adjudged non-diphtheritic by the author. There was a history of sore-throat, and on admission to hospital the muscles of the trunk became so weak, that he could not turn in bed: the tendon-reflexes were entirely absent. The author came to the conclusion that the patient's primary attack had been, not diphtheria, but one of tonsillitis: the

paralysis came on while the primary disease was still acute, instead of a few weeks afterwards. Permanent loss of muscular tissue has taken place with consequent permanent paralysis—an occurrence which the author has never found in diphtheritic paralysis. The author lays stress on the alcoholic habits of this subject as having been a factor in the induction of his malady.

Case VII. This case is quoted as an example of so-called "alcoholic" paralysis. It presented two symptoms which bear some relation to diphtheritic phenomena—loss of power in the respiratory muscles, and a curious kind of difficulty in swallowing.

Case VIII. The difficulty in swallowing alluded to in the previous case, was also present in this. A clerk, aged forty-four years, had had syphilis ten years previously. Latterly he had sore throat, with impairment of voice, and some difficulty in swallowing both fluids and solids, but fluids alone troubled him and induced attacks of choking. A laryngoscopic examination by Dr. Semon revealed some small growths below the vocal cords, and paralysis of the arytenoid muscle, causing defective approximation of the arytenoid cartilages in phonation, and the formation of a triangular chink at the posterior extremity of the rima glottidis. The author then proceeds to describe the manners of choking: "There was no doubt the patient could swallow solids with perfect freedom. He could also, when drinking, perform the act of deglutition without any hitch. But invariably, within a second or two after a mouthful of fluid had been swallowed, and at a time, therefore, when it had presumably passed beyond the larynx, and reached the lower part of the œsophagus, he began to choke, and presently coughed up some of the swallowed fluid. The phenomena were just what might be expected to happen, when there is a communication between the œsophagus and the trachea."

The author explains these choking-fits by the fact that, in consequence of the non-approximation of the arytenoid cartilages during deglutition, the supra-glottic laryngeal cavity was incompletely cut off from the gullet; fluids were consequently driven into this cavity, and were thence sucked into the windpipe proper, causing choking. It was afterwards discovered that these choking fits could be averted by the patient swallowing while stooping, so as to bring his head between his legs.

The author remarks upon the combination of anæsthesia (of the laryngeal mucous membrane) and paralysis which exists in these alcoholic cases.

[In reference to Case VIII. we could have wished for further information, and especially for the views of the author in regard to prognosis and treatment.] **Hunter Mackenzie.**

LEGROUX. — **Diphtheria and Creosote.** *Journal de Ruault, February* 19, 1888.

CREOSOTE is a powerful anti-parasitic, and Dr. Legroux, who has under his care the patients in the Hôpital Trousseaux, has treated 68 little children during the last two months with this agent, and he shows us the result of his researches. Of 68 cases he had 30 cures, that is more than 3-7ths, and of the tracheotomized cases he has had one cure out of three.

These are very satisfactory statistics. The treatment was systematic, and as follows :—

1st. Constant pulverisation with creosote in the atmosphere.

2nd. Swabbings of the throat with creosote (repeated every 4 or 5 hours) with this solution :—

Glycerine, 20 grs.
Alcohol, 10 grs.
Creosote, 1 gr.

3rd. In the more serious cases administration of creosote hypodermically in the following mixture :—

Antiseptic olive oil, 180 grs.
Creosote, 20 grs.

1, 2, or 3 cubic centimètres of the solution are injected without causing local inflammation, and the temperature is thus lowered in proportion to the dose employed. **Joal.**

MOHAMMED, BEN. (Nekhach).—**Treatment of Diphtheria by Perchloride of Iron and Milk.** *Congrès d'Oran, March* 29, 1888.

THE author has treated twenty-one diphtheritic patients with perchloride and milk, and has obtained twenty cures, among which were two adults.

All these patients were treated from the beginning of the affection—before the period of asphyxia. The perchloride was administered (in a dose of from 25—30 drops in a glass of water, the dose of milk being from 1 litre a day). As adjuvants he recommends emetics, and pharyngeal swabbing, with a solution of perchloride. The author has obtained such brilliant results that he recommends this treatment as the specific for diphtheria. **Joal.**

BEAUPÈRE.—Chloroform Anæsthesia in Tracheotomy for Croup in Children. *Lyon Médical, March,* 1888.

THE author (a pupil of Professor Lerat) founds his remarks on twenty-six observations made at the Hôpital de la Charité. He maintains that the use of chloroform is indicated in tracheotomy for diphtheria in children, that it does not increase the asphyxia ; that it diminishes the laryngeal spasm, and that so far from predisposing to syncope, it is able to prevent it. The only cases in which its use is contra-indicated, are those in which there is extreme asphyxia, or which present pulmonary lesions. **Joal.**

NOSE AND NASO-PHARYNX.

LERMOYEZ.—On the Pathogeny of Hay Asthma. *Ann. des Mal. de l'Oreille, etc., March,* 1888.

A CRITICAL article àpropos of Leflaive's thesis, abstracted in the April number of this journal. Lermoyez says, "The nose is becoming

everything, is encroaching upon, and threatening to swallow up, all pathology. Before yesterday asthma, yesterday stridulous laryngitis, to-day aprosexia are made tributary to it. In the name of progress everything is snared or cut away." He controverts Hack's theory. Hay asthma is not a neurosis of nasal origin; three kinds of fact are opposed to this doctrine:—

1. In the numerous observations of reflex neuroses of nasal origin we meet with phenomena which are durable or return in a variable manner, but which never present the characteristic periodicity of an affection which only attacks persons during two months of the year.

2. The examination of persons suffering from real hay asthma has led to the conclusion that the nasal fossæ are, in the immense majority of cases, in a perfectly healthy condition.

3. Finally, in those rare cases where we meet with the coincidence of symptoms of hay asthma with appreciable nasal lesions, the destruction of the nasal alteration has never led to the disappearance of the annual attacks. Real hay asthma should therefore be withdrawn from the category of reflex, nasal neuroses. **Joal.**

COUPARD.—Foreign Bodies in the Right Nostril. *Soc. Médecine Pratique, March* 15, 1888.

A LITTLE girl six years old suffered from ozæna from the age of seventeen months; she breathed with difficulty, had bronchitis, palpitation, oppression, and venous dilatation at the root of the nose. In 1886 a physician declared the child to be tuberculous. On examining the right nostril, a dry, blackish, thick crust was seen to be situated at the level of the middle meatus. Nothing was detected on the left side. With duck-billed forceps, Coupard removed a metal button. A month after the child was completely cured. **Joal.**

POTTER, F. H. (Buffalo).—**Tuberculosis of the Nose, Mouth, and Larynx.** *Buffalo Med. and Surg. Journal, February*, 1888.

A GOOD review of the subject.

HINKEL, F. W. (Buffalo).—**Irregularities of the Septum Narium, without Deflection, as an Etiological Factor in Nasal Catarrh.** *New York Med. Journal, October* 1, 1887.

BELIEVES them to be due to hereditary peculiarity of development rather than to trauma. A good paper, containing, however, no original matter.

J. N. Mackenzie.

SEILER, CARL (Philadelphia).—**Ecchondroses of the Septum Narium and their Removal.** *New York Med. Record, February* 18, 1888.

HE believes that simple cartilaginous excrescences are due, not to traumatism but to local irritation of the mucosa of the cartilaginous septum primarily, and of the perichondrium secondarily; and furthermore argues that this result is brought about through pressure irritation; thinks that excessive growth of ecchondroses often causes union between them and the opposite

turbinated bone, and that in this way the bridges met with in the nostril are formed, and cites an illustrative case. In operating, Seiler prefers the knife and gouge to the revolving instruments and saw. Having reduced any existing hyperæmia, the nostril is made anæsthetic with cocaine, a double-edged knife, curved on the flat, is carried from below upward to the middle of the excrescence, and then from above downward till the cuts meet. If a hard centre is present, a flat chisel and mallet are used to overcome the obstruction. When there is a shelf-like ecchondrosis, with a downward-sloping upper surface, separated from the floor of the nose by a narrow space, he assumes that ossification has taken place, and operates as follows :—

Dilating the nostril widely, the dull point of a plough-shaped knife is inserted into a grove director placed between the floor of the nostril and the ecchondrosis. When the bony centre is reached the knife is removed and a gouge is inserted, and a few blows from the mallet causes the obstruction to yield. These operations are painless, if cocaine anæsthesia is resorted to. The hæmorrhage is usually slight, and healing occurs in about ten days. For further details the original article should be consulted. **J. N. Mackenzie.**

GRADLE, H.—On Ocular Symptoms due to Nasal Disease. *Arch. of Ophthalmology*, Vol. xvi., No. 4, 1887.

THE principal symptoms considered are lachrymation, feeling of fulness of the lids, itching, pain in the eyes on their opening, congestion of the conjunctiva, sudden congestion and œdema of the lids, pericorneal injection. The author believes in the nasal origin of these symptoms, and holds the local cavernous obstruction theory of Hack. **J. N. Mackenzie.**

SCHMIDT.—Bilateral Amaurosis following Loss of Blood after a Nasal Operation. *Klin. Monatsbl. für Ohrenheilk., October*, 1887.

A LADY, twenty-three years of age, became blind after an operation for nasal polypi, during which she had lost 150—200 grms. of blood.

Michael.

CORIVEAUD.—Choreiform Convulsions of Reflex Origin in a Foster-child suffering from Coryza. *Journal de Bordeaux, December*, 1887.

THIS case relates to a child who for two days had presented choreiform movements. A careful study of all the organs and external circumstances threw no light on the etiology. The author then thought of nasal affection, and found that the mucous membrane of the nostrils was red and swollen. He found on it small mucous concretions. Warm fomentations, oily inunctions, rapidly modified the coryza, and dispersed the convulsive phenomena. **Joal.**

STONHAM, C. (London).**—A Case of Naso-Pharyngeal Polypus. Lawrence's Operation: Recurrence. Second Operation: Recovery.** *Lancet, January* 7, 1888.

THE patient was a boy aged sixteen years. The symptoms presented

by him were such as are usually associated with naso-pharyngeal tumours. The tumour seemed of the size of a hen's egg ; it was attached by a very broad base to the basilar process and to the left naris, extending backwards to, but not implicating, the vertebral column. Laryngo-tracheotomy was performed as a preliminary step, and Trendelenburg's tampon canula was employed.

Within six months after removal of the polypus by Lawrence's operation, recurrence had taken place. The same operation was peformed as on the first occasion, and the growth was completely removed in one piece. Three years have now elapsed without signs of further recurrence

Hunter Mackenzie.

FONTAN (Toulon).—**Temporary Maxillo-malar Resection for the Cure of Naso-pharyngeal Polypi.** *Congrès de Chirurgie, March* 1888.

IN the case of a boy aged sixteen, with an enormous polypus filling all the facial cavities, obstructing the pharynx, preventing deglutition, respiration, sleep, and causing frequent hæmorrhage, and in which it was necessary to act promptly, the author first divided the external orbitary apophyses through a small cutaneous opening. He then divided the palatine vault and the roof of the palate, separated the pterygo-maxillary articulation, and with the malo-maxillary bone removed the polypus, then brought the parts together by the osseous and cutaneous sections. The polypus weighed 100 grammes ; the maxilla was reunited on the fifteenth day. **Joal.**

HERMET.—Cauterization of the Posterior Region of the Turbinated Bodies. *Soc. de l'Elysée, February*, 1888.

THE author presented to the Society a spiral cautery, by which eight to ten cauterizations can be made at once. Hermet operates most frequently through the mouth ; the operator has the advantage of seeing what he is doing, and of measuring the exact extent of the cauterizations.

Joal.

POESCHEL.—The Treatment of Diseases of the Naso-pharynx. *Münch. Med. Wochenschr.*, No. 14, 1888.

A RECOMMENDATION of insufflations of boric acid. **Michael.**

MOUTH, TONSILS, PHARYNX, &c.

BROCA.—Complex Hare-lip of the Upper Lip. *Journal de Ruault, February*, 1888.

THE author sums up the works already published in the bulletins of the Soc. Anatomique, in the annals of gynecology in the Gaz. Hedomadaire, and he relies on fourty-four cases which he has observed, to refute Goethe's theory, and confirm the opinion of Albrecht. **Joal.**

LLOYD, JORDAN (Birmingham).—**Composite Odontome of the Upper Jaw. Removal.** *Lancet, January* 14, 1888.

ACCORDING to Heath, there are but nine cases of this form of odontome recorded, and these all occurred in the lower jaw. The present case i the only one on record in connection with the upper jaw.

Hunter Mackenzie.

QUENU.—Maxillary Fistula. *Soc. de Chirurgie, March* 28, 1888.

QUENU, after having opened a maxillary cyst through the mouth, closed the fistula with a palato-gingival flap, and a labial flap, without any kind of suture.

(See the discussion of the Chirurgical Society. March 28.) Joal.

HADDEN, W. B. (London).—**Suppression of the Salivary and Buccal Secretions.** *Lancet, January* 21, 1888.

THE author refers to a case recently exhibited by him before the Clinical Society of London. A detailed report has not yet appeared. Benefit was derived from the use of jaborandi. Hunter Mackenzie.

ROWLANDS, WILLIAM (Great Crosby).—**Permanent Suppression of the Salivary Secretion** (?). *Lancet, January* 14. 1888.

A LADY, aged sixty, received a shock by the sudden death of a friend. She awoke next morning with an intense dryness of the mouth and throat, which has remained ever since. The tongue is stated to have now the appearance of a piece dry raw beef. There are no signs of papillæ on the anterior surface, but the circumvallate are distinguishable.

The author invites information on the subject. Hunter Mackenzie.

BUXTON, A. S. (London).—**Complete Suppression of Saliva, after Mumps.** *Lancet, January* 21, 1888.

REFERENCE to a case published by the author in the *Lancet*, 1883. He remarks upon the paucity of such cases. Hunter Mackenzie.

COOPER, ARTHUR (London). — **Communicability of Syphilis through the Saliva.**

REFERRING to the communication of Carleton (*Journal of Laryngology*, Vol. II. p. 158), the author remarks upon the unusual fact of the disease having been derived from the subject of *tertiary* disease, and asks several pertinent questions. (Our readers will remember that we also directed attention to this particular point). Hunter Mackenzie.

PHILIP, R. W. (Edinburgh).—**A Contribution towards the Etiology of Phthisis.** *British Medical Journal, January* 28, 1888.

AMONGST the conclusions arrived at by the author are these : That the lethal influence of the bacillus (of tubercle) is due to the production thereby of certain poisonous products ; that this product, which is separable from the sputum, possesses well-marked physiological (depressant)

properties, and is eminently toxic to animals; and that this toxic action of the product is more or less completely opposed by atropine.

The author details a number of carefully-conducted experiments on frogs and mammals, and describes his method of separating the toxic products from the sputum. **Hunter Mackenzie.**

VERCHÈRE.—Treatment of Ranula. *Journal de Ruault, February*, 1888.

THE tumour is punctured with a Pravaz's syringe, a solution of cocaine 10 per cent. is injected, and four minutes afterwards, when the anæsthesia is complete, twelve drops of a solution of chloride of zinc (one-tenth) are introduced. The needle is then drawn out, and for two or three days the patient keeps as much silence as possible, and avoids food requiring prolonged and active mastication. Four patients suffering from sub-lingual ranula were cured by this treatment, which is not too painful. **Joal.**

GUINARD.—Congenital Ranula from an Imperforate Wharton's Duct. *Gaz. Hebdomadaire, January* 6, 1888.

GUINARD believes that this variety of ranula is rarer than is commonly supposed; he has made bibliographical researches, and has only been able to find nine well-authenticated cases in medical literature: Two in Riches' thesis (1882); two in Remignon's thesis (1885); one case of Demons' (*Bull. Soc. Chir.*, tome. vi.); two cases of Lannelongue, Ibid.; one case of Guyon, Ibid.; and, finally, one recent case of Verneuil's. **Joal.**

WHITEHEAD, WALTER (Manchester).**—Excision of the Tongue.** *Lancet, January* 28, 1888.

THE author contrasts the method of operating with which his name is associated—removal of the tongue through the mouth by means of scissors—with others, and shows that it is decidedly the best in regard to smallness of hæmorrhage, diminution of septicity, and rapidity of convalescence. **Hunter Mackenzie.**

GILLOT.—Semiological Value of Ampullary Dilatations of the Tongue. *Congrès d'Oran, March*, 1888.

THERE is a close relationship between ampullary or aneurysmal dilatations of the tongue, and the analogous alteration of the cervical capillaries. These vascular lesions are related to the arthritic diathesis, and prognosticate the imminent danger of cerebral lesions. **Joal.**

MAURIAC, CH.—Description of Tertiary Syphilitic Glossopathies. *Semaine Méd., March* 2, 1888.

THIS was a lecture given at l'Hôpital du Midi. The professor passes in review the functional symptoms of glossopathies; then the objective signs. He discusses the differential diagnosis of cancer, tuberculosis, and psoriasis from syphilitic lesions. *Apropos* of lingual psoriasis, he says that the difficulties of diagnosis are great. "There are hardly, in all pathology, two affections which so strikingly resemble one another, which intermingle and combine in such an intimate manner, as psoriasis

and sclero-gummatous glossopathies." He adds that, in syphilis the tumefaction is ordinarily more pronounced than in psoriasis. In the latter affection there are also produced on the diseased surface plaques, and more or less thick regions of hyperplastic epithelium, which are pathognomonic from the milky appearance, or silver-white colour (as if the surface had been touched with lunar caustic). In psoriasis the sclerosis remains dermic, it lobulates the dorsal surface of the tongue, and ridges the edges, but the little islets and streaks of affected tissue which result are different from the lobular buds, and crevasses of sclero-gummatous atrophy. The lecture, which is very scientific, will be read with great interest.

Joal.

FERRIER, DAVID (London).—**Clinical Lecture on Paralysis of the Fifth Cranial Nerve.** *Lancet, January* 7, 1888.

THIS is supposed to have been due to two causes—a predisposition, induced by syphilis, with traumatism as the exciting cause.

The author remarks that this case "lends no support to the usually accepted doctrines respecting the innervation of the palate by the fifth nerve; nor are these in accordance with the facts of recent experimental research. Vulpian has found in dogs that no movements are induced in the palate by irritation of the roots either of the fifth or facial nerve. But, on the other hand, movements of the soft palate are produced by irritation of the spinal accessory, or accessorio-vagus. That the spinal accessory is a motor, if not the only motor, nerve of the palate is also supported by similar experiments by Beevor and Horsley on monkeys. It is clear, therefore, that the whole subject of the motor innervation of the palate, and the current theories respecting the affections of the palate, in relation to disease of the fifth and facial nerves, require reconsideration and revision."

The following were amongst the features of the case:—Inability to open the mouth widely: when open, deviation of the chin towards the right side. Tongue protruded straight: both arches of palate rise normally and equally during inspiration and phonation. There is complete anæsthesia and analgesia on the right side of the nose and right cheek, with complete insensibility of the right nostril and the mucous membrane of the mouth as far back as the tonsil, and a similar condition over the whole of the right side of the tongue. There was slight ulceration of the mucous membrane of one cheek, and the patient could not feel his food when he chewed it on that side. Smell was slightly diminished in the right nostril; but he was able to recognize the smell of menthol, though less distinctly than with the left nostril. The palate was perforated on the right side, probably from old syphilis.

These symptoms are such as could only be caused by some lesion impairing the continuity of the trunk of the fifth nerve, both sensory and motor. The defective sense of smell was attributed, not to any lesion of the olfactory nerve, but to the affection of the mucous membrane of the nostril associated with total loss of sensibility.

The author discusses very fully the question as to the origin and course

the nerves which minister to the sense of taste in the anterior two-rds of the tongue. The glosso-pharyngeal is the special nerve of aste of the posterior third of the tongue and adjoining regions, while the chorda tympani, *per* the lingual division of the fifth nerve, supplies the anterior two-thirds. This case, and others quoted by the author, would appear to show that this method of nervous supply is not by any means a constant one, and that considerable ambiguity still exists in regard to those questions.

The treatment presented consisted of the administration of iodide of potassium in twenty grain doses, thrice daily, and faradization of the right side of the face. Steady improvement had ensued. **Hunter Mackenzie.**

HILLABY, A. (Pontefract).—**The Treatment of Tonsillitis by Salicylate of Sodium.** *Practitioner, April*, 1888.

THE following plan of treatment is recommended : Open the bowels freely with a good dose of Mistura Sennæ Co., put the patient on milk diet, and administer the following draught :—

℞ Sodii Salicylatis, grs. x—xv.
Tincturæ Aurantii Corticis ℥ x.
Aquam ad ℥j.
M. fiat haustus, quartis horis sumendis.

The dose of the salicylate should be reduced as the inflammation subsides.

Dr. Charles Graham, of Pontefract, writing on the same subject in the May number of the *Practitioner*, says that in incipient cases, and especially those occurring in gouty or rheumatic habits the drug acts like a charm. In cases where there have been several recurrences small doses do no good, and large ones sometimes fail. In such cases he has found bicarbonate of sodium, in doses of from ten to twenty grains every two or three hours, very useful. It appears to be equal to the salicylate in subduing inflammatory action and preventing suppuration, and it is free from the tendency to produce tinnitus, vertigo, and deafness.

Maxwell Ross.

POTTER, F. H. (Buffalo).—**The Galvano-Cautery in the Treatment of Enlarged Tonsils.** *Medical News, Philadelphia, March* 10, 1888.

AFTER reviewing different opinions on the treatment of enlarged tonsils, Potter sums up his article by recommending galvano-cautery puncture as safe, easy to manage, painless, and sure, while it preserves rather than destroys organs which it is rash to say are of no use in the economy.

J. N. Mackenzie.

VILLAR.—Lymphadenoma of the Tonsils; Involvement of the Pericardium and Heart. *Soc. Anatomique, March* 2, 1888.

VILLAR found in the Ecole pratique a patient suffering from a very large tumour of the pericardium, invading the heart and principally the right ventricle. Histological examination showed it to be lymphadenoma. This patient had been treated for a tonsillar lesion recognized as

malignant, after having been put under anti-syphilitic treatment. Besides this, the glands of the neck had developed enormously, and asphyxia threatening, tracheotomy became necessary. This prolonged life for three months. On auscultation of the heart it was thought that there was insufficiency. **Joal.**

TISSIER.—Follicular Amygdalitis and Contagion. *Ann. Mal. Oreilles, February*, 1888.

FROM the 1st to the 22nd August, 1887, the author has observed in the same hospital ward six cases of follicular amygdalitis of more or less intensity following a case which was admitted on the 27th of July. He does not think that this slight epidemic can be attributed to atmospheric influence, for in the neighbouring ward there were no similar cases. The constitution of the sufferers would not be impaired. All the persons affected were in good health; there must therefore have been undeniable contagion. **Joal.**

CARPENTER, ALFRED (Croydon).—**Some Slight Throat Affections: their Nature and Treatment.** *Practitioner, April*, 1888.

UNDER the above title, Dr. Carpenter describes a class of cases of a mixed character, which, however, agree in one particular, that they are preceded by sore throat, with which suspicious circumstances are connected, such as diphtheria in the house or neighbourhood. After the throat affection has subsided, other symptoms may arise indicating congestion of lungs, liver, kidneys, or other organs, and attended with high fever. In one case, there occurred, after the sore throat, renal disturbance, then pneumonia, then jaundice and acute rheumatism, with cardiac complications, before recovery took place. The author associates these cases with blood mischief connected with some diphtherial poison, and indicated by specific action in the throat. He suggests that the diphtherial germ has aborted, as it were, but the mischief is in the tissue of the throat, and from it passes into the blood, where its "resting spores" block up the capillaries in various organs or glands, one after another. Development goes on, and conditions are produced which are not in themselves infectious to others, but only to the host himself. Treatment in these cases should be directed to the first cause. Local colonies of the microbe in the throat should be destroyed by applications of quinine or powdered sulphur and pure charcoal on the tonsils, and by injecting these into the nasal passages. A spray of permanganate of potassium solution and the internal administration of the salt are also recommended. Sodium sulpho-carbolate should be given for fever; and if stimulants are found necessary, ammonia is preferable to alcohol. **Maxwell Ross.**

WEIL (Stuttgart).—**Treatment of Chronic Pharyngitis.** *Monats. für Ohrenheilk.*, No. 3, 1888.

A RECOMMENDATION of brushing with acetum pyrolognosum crudum, and application of Paquelin's thermo-cautery instead of the galvano-cautery. **Michael.**

HAGER (Wandsbeck).—**Acute Infectious Phlegmon of the Pharynx.** (*Senator*) *Berl. Klin. Wochenschr.*, No. 12, 1888.

THE patient, thirty-nine years of age, became feverish, with difficulty of swallowing and delirium. There were swelling of the tonsils and redness of the pharynx. Some days later, enlargement of the sub-maxillary glands occurred. Fourteen days later the glands of the neck were swollen to a high degree, and were very hard. The infiltration also invaded the cranial integument, so that the patient could not move the head; there was also difficulty of respiration, so that tracheotomy seemed to be necessary. Improvement was produced by cataplasms. Ten days later, there were swelling and pain in the spleen, and in some joints. The treatment was antipyrine and alcohol, and mercurial ointment externally. Slow recovery followed. **Michael.**

BARUCK (Paderborn).—**Acute Infectious Phlegmon of the Pharynx.** *Berl. Klin. Wochenschr.*, No. 13, 1888.

A PATIENT, fifty-eight years old, was attacked with laryngo-stenosis some days after his son was cured of facial erysipelas. There was nothing abnormal in the pharynx. The laryngoscope showed, however, œdema of the larynx. The general condition was feverish. Tracheotomy was performed. Some days later, erysipelas of the wound appeared. Five days later, the canula was removed. Three days later, sudden death resulted from paralysis of the vocal cords. [There is no reason for calling this condition infectious phlegmon of the larynx — *Senator.* There was nothing in the pharynx except acute œdema of the glottides. The wound of the trachea became erysipelatous, because the son had been in the same room.—REP.] **Michael.**

M.D.—Treatment of Pharyngeal Syphilis. *British Medical Journal, January* 7, 1888.

THE author asks for suggestions of treatment of a patient who, about twelve years ago, contracted syphilis from a coloured woman. Primary and secondary symptoms developed. About a month or six weeks ago, sores appeared on the fauces and soft palate, and when seen by the author, the entire buccal surfaces, hard and soft palates, and angles of the mouth, were a mass of deep, ragged, sloughing ulcers. Patient had been ordered mercury, with quinine and belladonna.

[We think that the iodide of potassium in large doses before food would be more suitable to the stage of the disease than mercury.]

Hunter Mackenzie.

HOUTANG.—Softening Gumma of the Pharynx Simulating Retro-Pharyngeal Abscess. Incision. Cure by Specific Treatment. *Ann. Mal. Oreilles et Larynx, February*, 1888.

THE most interesting facts described in this case were the following. On examining the throat, the posterior part of the pharynx was seen to be pressed forwards, and forming a smooth convex surface, which was applied to the free edge of the roof of the palate, the faucial pillars, and the base of the tongue. There was no change in the colour of the mucosa. On

introducing the finger, a tumour was found to exist in front of the vertebral column, almost median, a little more developed, however, on the right than on the left side. There was no glandular enlargement, and no trace of scrofulous, tuberculous, or syphilitic diathesis. Nevertheless, Millard suspected syphilis, and the result of specific treatment showed that his diagnosis was a correct one. The author deduces from this observation that syphilitic antecedents should be sought for in every case of retro-pharyngeal abscess in the adult. **Joal.**

MOURE.—Mycosis of the Pharynx. *Congrès Avancement des Sc. à Oran, March*, 1888.

Up to the present date, twenty cases of pharyngeal mycosis have been published. Some authors consider this affection rare. It is not so at all; the affection, almost common, passes unperceived. Then follow etiological and symptomatological considerations, remarks on diagnosis and treatment, the microscopical researches that Moure has consigned to his pupil Mendes Bonito, who has written a good thesis on the subject. (See April No., 1888, page 160.) **Joal.**

BURKHARDT (Stuttgart). — **On the Operative Treatment of Retro-Pharyngeal Abscesses.** *Württ. Correspond.-bl.*, 1888, No. 9.

The author proposes to open these abscesses not by the mouth, but by incision through the lateral region of the neck. He relates three cases in which he has performed the operation with good results. **Michael.**

MELTZER (New York).—**Case of Dysphagia, with Remarks.** *Berl. Klin. Wochenschr.*, 1888, No. 89.

The lady has had a very rare affection of deglutition for 19 years. At times, everything she swallows remains in the œsophagus, and only after some hours descends into the stomach. Whilst the food is in the œsophagus she can reject it easily, but the vomit has never the acid taste and odour which is customary. When the food is in the stomach she can never reject it, and neither can she reject air from the stomac through the mouth. A probe can, with some difficulty, be introduced into the stomach, but if the introduction is repeated, it requires the use of greater force. The very interesting proof that the affection is a neurosis, must be read in the original. **Michael.**

TERRILLON.—Stricture of the Œsophagus: Gastrotomy. *Acad. de Méd., March* 6.

A case in which gastrotomy was successfully performed in a man seventy-three years old, for malignant stricture. **Joal.**

AUDRY.—On Stricture of the Œsophagus from Muscular Hyperplasia. *Bull. Méd., April* 4, 1888.

Two patients in the practice of Dr. Poucel were attacked with œsophageal stricture; the surgeon had thought them to be cancerous. His-

tological examination showed that in both cases there was simple hyperplasia of the muscular coat. Audry concludes, first, that there really exists œsophageal stricture from muscular hyperplasia. Second that this form of lesion is rare, and its diagnosis often impossible. Thirdly, that whenever it is suspected, early gastrotomy is indicated.

Joal.

LARYNX.

SEILER, CARL (Philadelphia).—**Physiology of Voice and Speech.** *Reprint from the American System of Dentistry, Philadelphia*, 1888.

AN able paper on the subject, which, to be appreciated, should be read in the original. **J. N. Mackenzie.**

BRACHET and COUPARD.—Hygiene of the Vocal Organs. *Paris: Dentu*, 1888.

FRENCH translation of the Third Edition of Sir Morell Mackenzie's book. **Joal.**

BRUGELMANN (Inselbad, Paderbon).—**On Asthma.** *Deutsch. Medizinalztg.*, 1888, Nos. 29, 30, 31.

A WELL-WRITTEN article, reviewing the different causes of bronchial asthma, the treatment of the disease, and recent theoretical views upon it. **Michael.**

SEIFFERT and HOFFA (Würzburg).—**Case of Congenital Membranous Formation in the Larynx treated by Laryngo-fissure and subsequent Catheterism.** *Berl. Klin. Wochenschr.*, 1888, No. 10.

THE patient, a young lady, was born with stridor, and could never cry aloud. When one year old she began to speak, but always in a whisper. She was always cyanotic, and could never breathe freely. The laryngoscope showed that the vocal cords were joined together with a membranous septum. It was impossible to improve her condition by an intra-laryngeal operation, therefore tracheotomy, tamponning of the trachea, and laryngotomy was performed, and a thick membranous tissue was removed. The cartilage of the cutaneous wound was then sutured. The patient was treated afterwards with Schrötter tubes. Respiration and voice are now very good. **Michael.**

LENICKE (Rostock).—**Contribution to the Treatment of Cicatricial Laryngo-Stenoses.** *Berl. Klin. Wochenschr.*, No. 13, 1888.

THE patient has had phthisis of the larynx and lungs, and has been cured of both affections, but remains hoarse. Three years later he suffered

from laryngo-stenosis, and almost complete aphonia. The mucous membrane of the larynx was normal. In place of the true ligaments is a cicatricial membrane, with only a small lumen. Tracheotomy was performed, and treatment with Schrötter's bougies was tried, but without success, in consequence of the bougies causing great pain to the patient. The larynx was filled with cicatricial masses of irregular form, which rendered the introduction of the bougies impossible. These cicatricial neoplasms were destroyed with the thermo-cautery, and the wound closed by suture. The treatment with bougies could then be continued, and after some time the patient was completely cured. **Michael.**

KOCH.—Phonetic Spasm of the Glottis. *Ann. Mal. Oreilles, March,* 1888.

SPASMODIC aphonia should be classed with neuroses of "vocation" or "occupation": it can be compared to the cramp of piano or violin-players, of shoe-makers, &c. *Apropos* of two cases he has just observed, the author remarks that parenchymatous goître may produce this aphonia. His two patients were suffering from goître involving the right lobe of the thyroid gland. One of Jonquière's patients and a patient of Schech were affected with the same hypertrophy. It may be surmised that the irritation of the recurrents produced by the compression of the goitre, combined with irritation emanating from a central source, causes a phonetic spasm through the inferior laryngeal nerve, a condition which neither of these two agents could produce separately. **Joal.**

REMAK (Berlin).—**Traumatic Paralysis of the Sympathetic, Hypoglossal, and Accessory Nerves.** *Berlin. Klin. Wochenschr.*, No. 7, 1888.

DURING the extirpation of a carcinoma of the circumference of a goose-egg, a portion, six centimetres long, was removed from the right cervical sympathetic. There followed a deviation of the tongue to the left side, but taste and sensibility were not altered. The patient's larynx was examined with the laryngoscope. Before the operation it showed no abnormality, but after the operation the right vocal band was paralyzed, but it did not remain in the cadaveric, but in the median position, as in posticus-paralysis. In this case there was an artificial paralysis of the posticus muscle.

There was no reason to believe that it resulted from irritation, and it was probably a true paralysis. **Michael.**

ROSENBACH, OTTOMAR (Breslau).—**On the Different Vulnerability of the Fibres of the Recurrent Nerve.** *Berlin. Klin. Wochenschr.*, No. 8, 1888.

SEMON (London).—**On the Different Vulnerability of the Fibres of the Recurrent Nerve.** *Berlin. Klin. Wochenschr.*, No. 10, 1888.

CLAIMS for priority. **Michael.**

FRÄNKEL, B.—Remarks on Remak's Case of Traumatic, etc., Paralysis. *Berlin. Klin. Wochenschr.*, No. 8, 1888.

THE author agrees that this case is a certain confirmation of the views of those who hold the paralytic, as opposed to the irritative theory, and that, therefore, it is of eminent importance. **Michael.**

OKELL, J. B. (Leicester).—**Tracheotomy in Tubercular Laryngitis.** *Provincial Medical Journal, April*, 1888.

THE operation was done on a man aged thirty-four, after respiration and pulse had stopped. Artificial respiration, ether, and brandy, brought him round, but five and a half hours elapsed before he recovered consciousness. The writer states that a week later an examination was made of the larynx, and advanced tubercular disease found to exist. The usual symptoms appear to have been absent, and there was no evidence of pulmonary mischief, nor were the bacilli found, though looked for. The patient continued to wear a vulcanite tube when he left hospital, and it is stated that the operation greatly improved his voice and general health, rendering him able to do his work well, whereas before it he had great difficulty in following his employment. **Maxwell Ross.**

MACKENZIE, G. HUNTER (Edinburgh).—**Case of Thyrotomy for Recurrent Growths in the Larynx; with Remarks.** *Edinburgh Medical Journal, December*, 1887.

A WOMAN, aged thirty-five, commenced in October, 1884, to suffer from hoarseness from laryngitis. On the 18th December following, a warty-looking growth was detected at the anterior commissure of the vocal cords. A piece of this was removed, and, on microscopical examination, was quite negative, so far as regards malignant disease. The patient, who was pregnant, was remarkably insensitive to the action of cocain, and complete extirpation of the neoplasm could not be accomplished by endo-laryngeal means. On 9th June, 1885, thyrotomy was performed, the growth was removed, and its seat of attachment was cauterized with solid nitrate of silver. This, however, did not prevent recurrence, for by September of the same year the growth was again present in its former situation, apparently in a more luxuriant form than ever. Thyrotomy was again performed, the base on this occasion being freely and deeply cauterized with the thermo-cautery. The growths were of a simple papillomatous nature. The patient made a good recovery, and quite regained her voice in about six months. She was not seen again by the author until over two years had elapsed, when she again consulted him. It was now found—(1) the old growth had not recurred; (2) from the posterior third of the left vocal cord there sprang a sessile growth of exactly similar appearance to those already described, and a little larger than a pea. A growth similar in character to those in the larynx commenced shortly afterwards to grow from the mucous membrane of the hard palate, just behind the incisor teeth.

The author remarks upon the beneficial effects from the use of the thermo-cautery, and, in regard to the diagnosis of the nature of growths upon the vocal

cords, states "that in malignant disease the mobility of the corresponding vocal cord is at an early stage markedly impaired or altogether lost, and that apart from the merely mechanical hindrances to movement incidental to the position and size of the growth." Some observations are made upon the value of microscopical examinations of portions of laryngeal neoplasms removed for the purpose, and upon the effect (which the author believes to be entirely suppositious) of endo-laryngeal operations in causing or hastening the malignant transformation of previously benign growths. **Hunter Mackenzie.**

SMITH, THOMAS (London).—**Removal of Foreign Bodies from the Air-passages.** *Lancet, January* 28, 1888.

A LETTER to the Editors, correcting a mistake which had arisen in connection with the author's suggestion, that the margins of the tracheal wound should be sutured to the skin during operations for the removal of foreign bodies from the air-passages. This attachment is meant to be a *temporary* one, and the sutures ought to be divided so soon as the foreign body is removed. **Hunter Mackenzie.**

L'ABBÉ, LÉON.—Foreign Body in the Larynx. *Congrès Chirurgie, March,* 1888.

L'ABBÉ exhibited a metal star, part of a plaything, extracted by him from the larynx of a child by laryngotomy. Dr. Cadier, with the laryngoscope, had seen clearly the star firmly fixed at the level of the vocal cords. Extraction *per vias naturales* not being possible, L'Abbé decided on performing thyrotomy, but wished to spare his patient preliminary tracheotomy, which Morell Mackenzie advises. The sequel proved him to be wrong. For at the moment when L'Abbé was about to seize the foreign body, some drops of blood fell into the trachea, and brought on immediate formidable attacks of suffocation, which necessitated tracheotomy. It took forty-five minutes to re-establish respiration by means of the usual methods. **Joal.**

DEMONS.—Extirpation of the Larynx for Cancer. *Congrès Chirurgie, March,* 1888.

A NUMBER of eminent surgeons have condemned the operation. Demons thinks that it should not be abandoned, and until a cure for cancer without operation shall be discovered he will continue to operate. He quotes two cases in favour of his views. In the first, in which the lesions were very extensive, the patient lived for nine months ; in the second, success was complete. The operation is a serious one, but it is a last chance for patients whose case is otherwise hopeless. **Joal.**

DU CAZAL.—Wounds of the Larynx. *Soc. Chirurgie, April* 4, 1888.

THE case of a soldier who, after having passed his evening in a café, was seized in the night, without apparent cause, with a fit of intense suffocation and great pain in the throat. He died the following day. At the autopsy, a small non-ulcerated wound was discovered on the

inferior vocal cord, apparently of recent date ; there was also œdema. Du Cazal thinks that the patient may have swallowed a piece of glass at the café, which entered the trachea, and, being expectorated by the coughing efforts, wounded the vocal cord. **Joal**

LUC.—Tracheal Ozæna. *Journ. de Ruault, February*, 1888.

IT is a generally-received opinion that in patients suffering from true ozæna, when the nasal fossæ are once cleansed, the unpleasant odour ceases, not to reappear until fresh mucous secretions soon drying re-form in the cavities. Three clinical cases observed by the author contradict this opinion, and establish the fact that in certain subjects with ozæna, the fœtidity of the breath has a dual origin, and that it proceeds both from the nasal fossæ and the trachea, and may therefore continue when the nasal fossæ are cleared by irrigation from the fœtid secretions they contain. According to Luc, Fraenkel of Berlin is the sole author who has already mentioned tracheal ozæna, and he has only mentioned briefly the existence of fœtid crusts in the trachea without in the least appreciating the clinical value of the fact, and without entering into their pathogenic signification, and without drawing any deduction from the prognosis and therapeutics of ozæna. The author maintains that tracheitis is secondary to rhinitis, but once originated it appears to evolve independently. The microscope reveals the presence in the tracheal secretions of micro-organisms similar to those contained in the nasal crusts in ozænic patients ; these are not migratory productions which have gone from the nose, but are originated *in sitû*. Tracheal ozæna is indicated clinically by expectoration of a greenish colour, viscous, thick, exhaling the odour of ozæna, especially in the morning, by the persistence of the fœtidity of the breath after nasal irrigation, and also by the fact that the air expired by the mouth is as fœtid as that from the nose. Besides the cases which he related in December at the Soc. de Méd Pratique, Luc brings forward two new observations fairly conclusive.

Joal.

NECK, &c.

PETIT, L. L.—Gaseous Tumours of the Neck. *Congrès Chirurgie, March*, 1888.

AFTER having studied the pathogeny and symptomatology of æroceles, the author says that contrary to the general opinion, certain of these tumours are susceptible of diminution and even of cure. They are those which have appeared suddenly during an effort not repeated, and without chronic affection of the respiratory tract ; the others remain *in statu quo* or increase. It is the opinion of many surgeons that these tumours are not always incurable ; some have been cured by compression, and narcotics internally. Perhaps in the future it will be possible to perform an operation analogous to the surgical one for abdominal hernias. **Joal.**

SEGOND.—A Case of Cystic Goître. *Gaz. des Hôp.*, *Feb.* 23, 1888.

A LECTURE given at the Hôpital de la Charité on a patient suffering from this affection. The professor enumerated the different methods of treating goîtres. He recommended interstitial injections of iodine for parenchymatous goîtres. Duguet has proved that this method gives marvellous results. Iodine injections are also employed in cystic goître, though they gave rise, in certain cases, to inflammatory complication, which, in the case of one of Segond's patients, even ended fatally. These injections sometimes produce an appreciable modification, and the patient in the present case has been already unsuccessfully treated by Trélat, and energetically demands an operation. Segond rejected antiseptic incision and total thyrodectomy, and decided on performing partial thyrodectomy.

Joal.

GAUTHIER, G.—On Thyroidean Cachexia in Basedow's Disease. *Soc. de Sc. Méd. de Lyons*, *March*, 1888.

THE author develops the idea that cachexia, occurring at a confirmed period of Basedow's disease, is connected, in a certain number of cases, with lesions of the thyroid gland. In twelve autopsies, the lesions consisted either of cirrhotic retraction, causing the glandular elements to disappear, or of hæmic cysts or sanguineous infarcts ; in a word, there was functional atrophy of the organ ; it is possible that these alterations determine the cachexia of exophthalmic goître in a manner analogous to that observed in "cretins," or persons who have undergone thyroidectomy.

Joal.

VIERORDT.—On the Combination of Goître and Laryngitis Hypoglottica. *Festschrift für Ernst Wagner von seinen Schülern*, p. 51.

THE author has observed two cases in which not only goître and laryngitis hypoglottica were seen together, but there was a relation between the two conditions, in so far that if there was an exacerbation of the laryngitis, there was also an increased swelling of the goître. It is possible that such cases are not so rare as is supposed. Many dyspnœic, hoarse, and goîtrous patients, never being examined with the laryngoscope.

Michael.

BALLET.—Paralysis of the Bulbar Nerves in Exophthalmic Goître. *Soc. Méd. des Hôp.*, *February* 24, 1888.

BALLET exhibited a patient suffering from hysteria and exophthalmic goître, and who had a very pronounced paralysis of the ocular nerves. He could not, indeed, move his eyes at all, and had paralysis of the third, fourth, and sixth pair ; however, the pupil had preserved its contractility, and the muscle of accommodation also. Besides this, the face of the patient is immobile and expressionless, which proves the existence of double facial paresis. The only bulbar nerves which appear to be intact are the hypoglossal and the motor branch of the trigeminal. The existence of these paralyses tend to disprove the sympathetic and pneumogastric theories of the pathological physiology of this affection ; and

Ballet admits with Sattler and Panas that the disease is situated primarily on the bulb. **Joal.**

HAW, W. H. (Wednesbury).—**Hæmorrhage in Myxœdema.** *Lancet, January* 7, 1888.

A SHORT record of a case with hæmorrhagic tendencies, "the bleeding here occurring probably from the lungs, and, at the menstrual period, the uterus." **Hunter Mackenzie.**

DAVIES, ARTHUR (London).—**The Hæmorrhagic Tendency in Myxœdema.** *Lancet, January* 14, 1888.

A RECORD of three cases confirmatory of the views of Dr. Shelswell, regarding the presence of a tendency to hæmorrhage in myxœdema (vide *Journal of Laryngology*, etc., Vol. II., p. 217). **Hunter Mackenzie.**

JALLAND (York).—**(1) Tumour of Left Parotid; (2) Malignant Diseases of Lower Jaw; (3) Myeloid Sarcoma of Lower Jaw.** *Lancet, January* 7, 1888.

IN the first case, the tumour, weighing nine ounces, was removed by a longitudinal incision. It consisted chiefly of cartilage. Facial paralysis followed the operation. In cases two and three portions of the jaw were removed. **Hunter Mackenzie.**

TILLAUX.—Deep Lipoma of the Neck. *Journ. Méd. et Chir. Pratiques, March*, 1888.

THE case of a man, aged fifty-six, looking healthy, but having on the lateral part of the neck, on the left side, a voluminous tumour, which first appeared nine years ago. This tumour extends to the pharynx, and hinders deglutition; it projects so far into the mouth that it might be considered a retro-pharyngeal tumour. Though it appears to fluctuate, it is not liquid, as an exploratory incision proves; neither is it a cyst. Professor Tillaux rejects also the hypothesis of cancer, or sarcoma, or lymphadenoma, and concludes it to be a lipoma of a rare kind. **Joal.**

WALTER (Munich).—**Report of the Polyclinic for Diseases of Children in Munich.** *Münchener Med. Wochenschr.*, No. 13, 1888.

SEVENTY cases of whooping-cough were treated by Michael's nasal insufflations. In all cases the attacks diminished in severity after two to five insufflations. One case was cured in fourteen days. **Michael.**

CONGRESS MEETING.

Congress of Physicians in Vienna.

Meeting, April 8, 1888.

V. GENSER.—*Pathology and Treatment of Whooping-Cough.*

A RECOMMENDATION of treatment with antipyrine. **Michael.**

REPORTS OF SOCIETIES.

Northumberland and Durham Medical Society.

January 12, 1888.

LYON, Dr.—*Puff and Dart removed from Air-Passages.*

EXHIBITION of specimens partly expelled by, and partly removed from a girl aged eleven years. Tracheotomy was performed five days after the accident, and removal of the foreign body was essayed in vain. Afterward, the wool was coughed up, and the needle was removed from the wall of the pharynx in which it had become imbedded after an attack of coughing and vomiting. The child made a fair recovery.

ROBERTSON (William).—*The Galvano-Cautery in the Treatment of Diseases of the Nose and Pharynx.*

PAPER read, but not reported.

Hunter Mackenzie.

Pathological Society of London.

January 3, 1888.

TREVES, FREDERICK (London).—*Angiomata of the Mouth and Tongue.* (Three cases.)

TWO were cases of arterial angioma of the tongue—a very rare condition. In one case the tongue presented several small, elevated, red growths, two as large as the half of a pea, others mere specks. They disappeared under the application of chromic acid: epistaxis then came on. Baumgarten had noted small red elevations on the mucous membrane of the nose, in cases of recurrent epistaxis. In the second case, a woman, near the edge of the tongue opposite the molar teeth, was a red, arterial angioma, which bled freely. The third case, also a woman, presented an angioma behind the two right incisor teeth, and about the size of a cherry. It pulsated freely, and gave rise to considerable hæmorrhage. It was attached to the dental periosteum.

The treatment of such cases is removal by chromic acid or by the cautery.

Hunter Mackenzie.

underland and North Durham Medical Society.

December 16, 1887.

DRINKWATER.—*Tracheotomy.*

EXHIBITION of an old woman on whom tracheotomy had been performed for laryngeal obstruction nine years previously. On laryngoscopic examination no obstruction was seen in the glottis, but the moment the woman tried to inspire through the natural air-passages, the glottis closed.

This condition of spasm of the glottis on attempting to remove the canula after tracheotomy, has long been recognized: it was first described by Trousseau.

Hunter Mackenzie.

British Medical Association: Nova Scotia Branch.

December 6, 1887.

MILSOM, Dr. (Dartmouth).—*Tetany.*

NOTES of a case read. In the discussion which followed, Dr. Deeble, A.M.S., instanced a similar affection in a lady who had suffered from malaria in India, and whose larynx and pharynx were principally affected by the recurrent spasms.

BLACK, Dr.—*Intubation of the Larynx.*

EXHIBITION of O'Dwyer's instrument. A discussion on tracheotomy *versus* intubation in diphtheritic croup followed, but is not reported.

Royal Medical and Chirurgical Society.

January 10, 1888.

CHEADLE, W. B., and SMITH, THOMAS (London).—*A case of Occlusion of the Left Bronchus by a Metal Pencil-Cap, and its Removal by Tracheotomy.*

A GIRL, aged nine years, was the subject of this communication. Urgent choking and dyspnœa followed the impaction of the foreign body; this was relieved after the passage of a probang, and the pencil-cap was supposed to have entered the stomach. Four days later, dulness and impaired respiration were observed over the left lung, and on the eleventh day there was marked dulness over the whole of the left side, absence of respiratory sounds except over a limited portion of the upper part in front, displacement of the stomach upwards towards the nipple line, and great retraction of the left half of the thorax. Respirations 30, pulse 92, temperature 97·8. Tracheotomy was performed, and the edges of the tracheal opening were attached by silk sutures to the margin of the skin. A pair of forceps specially made and curved were then introduced, and the foreign body was extracted from the left bronchus without difficulty. The patient rapidly recovered, and on the fourteenth day after the operation the only abnormal physical signs present were a slight deficiency of expansion and of respiration on the left side.

The entrance of a foreign body into the left, as compared with the right, bronchus, is not so rare as is commonly supposed. Out of thirty-one cases referred to in this paper, in eighteen it was the left bronchus, and only thirteen the right.

The entire absence of pulmonary inflammation in this case shows, according to the authors, that collapse is not the leading factor in the production of catarrhal pneumonia.

Attention was drawn to the lowered range of temperature during the period of pulmonary collapse, to the inadequate compensatory rise in pulse and respiration rate, and to the possible causes of a short phase of high pyrexia which occurred the day after operation.

The PRESIDENT (Mr. George D. Pollock) complimented the authors on their skill in diagnosis and treatment.

Mr. ST. GEORGE MIVART was sorry it had been found necessary to stitch the skin to the lips of the wound, as it left a large persistent scar.

Mr. HULKE had published a similar case in which the end of a tracheotomy tube became impacted in the right bronchus. He hooked it out with flexible crotchet of silver wire. He thought it important that these hard bodies did not swell up after impaction.

Mr. BARWELL referred to a case published by him in the Clinical Society's Transactions (1873), in which he had been unable to remove the foreign body. The boy suddenly took a turn for the better—probably owing to his coughing up and swallowing the obstructing object, and passing it by the bowel unnoticed.

Mr. HOWARD MARSH remarked upon the quickly varying nature of the physical signs in these cases.

Dr. HOWARD had been struck with two points in the case before them: First, the good effects of stitching the skin temporarily to the trachea; and, secondly, the advantage that would be gained by "having the tracheal point higher than any point above it, so that the blood should not drain into the lung." In reply to the President, who asked how this was to be brought about, he acknowledged that he had never done it. (It is somewhat difficult to comprehend what Dr. Howard means: How can we have the tracheal wound higher than any point above it?)

Dr. CHEADLE said it was generally the case that where the obstruction was

incomplete, there was not much dulness, but it was too sweeping an assertion that there was always reasonance after impaction. When there was any it slowly disappeared as collapse set in.

Mr. T. SMITH said he had found no long forceps so well adapted to this case as a pair which opened outwards with a firm grip. In many previous cases he had seen great difficulty in grasping the foreign body, and the operation had often ended in its being coughed up. He agreed with Dr. Howard "that the tracheal wound should be higher than any other part in the trachea." As regards stitching the edges of the trachea to the skin, he did not think any serious aggravation of scar would result.

Hunter Mackenzie.

Medical Society of London.

January 9, 1888.

FENWICK, HURRY (London).—*The Reflex Inhibitory Action of Cocain as a Diagnostic Factor.*

THE author read a paper upon a long series of cases in which pain in various parts of the body had been temporarily relieved in ½ to 3 minutes by urethral injections of a 20 per cent. solution of cocain. The following propositions were formulated:—1. Slight nerve irritations (as neuralgias) *of any part* can be relieved by injecting into the urethra a few drops of a 10 or 20 per cent. solution of cocain. 2. Severe nerve irritation, as in the pain of carcinoma, inflammation, etc., cannot be thus relieved.

Mr. JAMES BLACK inquired whether Mr. Fenwick had noticed any serious toxic symptoms after injections of 20 per cent. solutions of cocain. In two cases in which he had used a 20 per cent. solution to remove a growth from the inferior turbinated bone, the patient became collapsed, livid, cold, and almost pulseless.

Mr. BOWERMAN JESSETT said he had removed an enlarged gland from the neck after the injection of 10 minims of a 20 per cent. solution, but serious symptoms had followed. He remarked upon the difficulty of obtaining relief from pain by cocain in case of removal of nasal polypi.

Mr. WALTER PYE said he had seen many cases of fainting after cocain. He himself had felt faint after the use of a 5 per cent. solution.

[We consider that not more than 10 minims of a 10 per cent solution of cocain should be administered subcutaneously. The use of strong cocain sprays to the nose and throat ought to be discontinued. The brush or a pellet of cotton wool left in contact with the part to be operated on, is preferable, and less likely to be followed by constitutional effects.]

TREVES, FREDERICK (London).—*On the Treatment of Carotid Hæmorrhage.*

(AN abstract of this Paper appears in our current number, page 225.)

Mr. BERNARD PITTS mentioned a case where there was copious hæmorrhage from a tonsillar abscess, and in which he tied the common carotid. The hæmorrhage recurred, with a fatal result. At the *post-mortem* examination, a large opening was found into the internal carotid near the abscess. He had made a series of experiments since, and found that blood escaped much more freely from such an opening when injected into the external carotid.

Mr. HARRISON CRIPPS thought it was preferable to ligature the external, than the common carotid. It was frequently the case that the hæmorrhage came from the tonsillar branches of the external carotid.

Mr. TREVES said the loop of which he spoke was in no sense a temporary ligature. Even in the child who died, the lumen was not obstructed. The suggestion to ligature the artery at the site of the wound would not be possible in a deep punctured wound.

Hunter Mackenzie.

January 23, 1888.

PITTS, BERNARD (London).—*Nævoid Growth of Tongue.*

CHILD shown. The affected part had gradually increased in size until it hung out of the mouth, necessitating the removal of a triangular piece of the tongue to reduce its size. The author proposed to try the effect of multiple applications of Paquelin's cautery.

MORGAN, JOHN (London).—*Case of Nævus of the Tongue.*

A MALE child was shown on whose tongue a nævoid growth was noticed when eighteen months old. Since then, it had only increased in size *pari passu* with the tongue, and as the author had several times witnessed the spontaneous disappearance of these growths, he decided to await the result of Mr. Pitt's experiment with Paquelin's cautery.

Hunter Mackenzie.

Royal Academy of Medicine in Ireland.

SURGICAL SECTION.

December 9, 1887.

THOMSON, W. (Dublin).—*Foreign Body in the Œsophagus.*

THE author submitted notes of two cases. In the first, the patient tried to swallow a quarter of a pound of beef, and was brought in dead. In the second, a piece of meat was felt to stick in the gullet, and a tube was introduced, followed by much pain, and by emphysema of the face and neck. Tracheotomy was necessary, and the patient soon announced that he was able to swallow freely. Death occurred the same night. Opposite the cricoid cartilage the œsophagus was transfixed by a bone which passed forward on the left of the trachea for a quarter of an inch. The posterior end also transfixed the œsophagus, making a rent through which fluids passed freely into the posterior mediastinum. A piece of meat, two inches long, hung from the bone.

Mr. TOBIN had seen a similar case. Œsophagotomy was performed, and a large triangular bit of bone was removed. The patient died six days after the operation, partly from exhaustion, partly from dyspnœa due to the extravasation of pus and fluids, and partly from septicæmia.

Other members took part in the discussion without being reported.

Hunter Mackenzie.

Clinical Society of Manchester.

December 20, 1887.

DARWIN, G. H.—*Œdema of Larynx.*

THE history of a case was related in which the œdema was produced by the action of brandy administered during an attack of syncope, and which was drawn by inspiration into the larynx, trachea, and bronchi. This resulted in inflammation, and the formation of straw-coloured blisters of the throat and larynx. Recovery ensued.

Hunter Mackenzie.

Cambridge Medical Society.

December 2, 1887.

ROPER.—*Sudden Death in Diphtheria.*

NARRATION of the case of a boy, aged twelve years, who died on the twelfth day of the disease. Very few symptoms, or local indications, were present until the eleventh day, when paralysis set in. On post-mortem examination the cavities of the heart were completely distended with clots, especially on the right side.

Hunter Mackenzie.

London : Pardon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Articles, p. 253.—Dr. Hermann Krause: On Disturbances of the Functions of the Larynx in Diseases of the Central Nervous System. Dr. E. Cutter: Food and Throat Affections.

New Instruments and Therapeutics, p. 262.—Alrath: Elastic instead of Silver Canulas in Tracheotomy. Lardy: Canula for Deep Stenosis of the Trachea. F. X.: Respiration in Winter. Baratoux: Stimulating Gargle. Weil: Carbonic Acid in Dyspnœa. Yersin: Action of Antiseptics and Heat on the Tubercle Bacillus. Raoult: The Dangers of Antipyrin. Loney: Naphthol in Stomatitis.

Diphtheria, p. 264.—Paquet: Diphtheria. D. . . . : Notes on Diphtheria. Jenny: Conditions following Tracheotomy. Oertel: Patho-genesis of Diphtheria. Riemer: On Diphtheria. Boyd: Ibid. Raymond: Diphtheria in Brooklyn. Mason: Permanganate of Potash in Diphtheria.

Mouth, Tonsils, Pharynx, &c., p. 267.—Küster: Neoplasms of Upper Jaw. Potter: Acute Tonsillitis in Children. Lehmann: Congenital Cyst of "Bursa Pharyngea." Rolland: Granular Pharyngitis. Gubb: Narrow Escape from Choking. Solis-Cohen: Artificial Administration of Food.

Nose and Naso-Pharynx, p. 269.—Rolland: Acute Rhinitis. Ziem: On Opening the Antrum of Highmore. Ringer and Murrell: Paroxysmal Sneezing. Genth: Therapeutics of Hay Fever. Joal: Genital Epistaxis. Hooper: Adenoid Vegetations.

Larynx, p. 272.—D'Heilly: Intubation. Radestock: Total Extirpation. Zeman: Angio-sarcoma of the Trachea. Noll: Dismemberment of the Trachea. Sommerbrodt: The Larynx of Ventriloquists. Bandler: Acute Œdema. Dehio: Primary Tuberculous Neoplasms. Averbeck: Massage. Onodi: Innervation of Larynx. Schüller: Cicatricial Laryngo-Stenoses. Garel: Specific Perichondritis.

Neck, &c., p. 275.—Hennes: Congenital Excrescences of Neck. Billroth: Scirrhus of the Thyroid.

Reports of Societies, p. 276.—Society of Physicians in Vienna; Medical Congress in Hamburg; Seventh Congress of International Medicine in Wiesbaden; Congress of Physicians in Hamburg; Congress of Physicians in Munich; Paris Surgical Society; French Society of Otology and Laryngology.

Reviews, p. 283.—Transactions of the Academy of Medicine in Ireland.—Annual of the Universal Medical Sciences.—Stoker: Deviations of the Nasal Septum.

Notes, p. 285.—American Laryngological Association; British Laryngological Association.

The Throat & Voice.

Chlorate of Potash Tabloids.

FOR AFFECTIONS OF THE VOICE, THROAT, AND RESPIRATORY SURFACES GENERALLY.

By using these Tabloids the drug is effectually brought in contact with the oral mucous surfaces as a continuous gargle, and its specific action made certain. In acute sore throat, Chlorate of Potash "usually relieves the uneasiness in a few hours" (Cohen). "It is used in ulcerated mouth and follicular pharyngitis, and has been employed in croup, diphtheria, and spasm of the larynx" (Brunton).



Retail price, 6d.

"Of convenient size, they are beautifully made; and, as they dissolve slowly in the mouth, are well suited for throat affections."—The LANCET.

Supplied in beautifully graven white metal boxes, blue silk label, at 6d. and 1s. each.

Chloride of Ammonium Tabloids.

The solvent and discutient as well as antiphlogistic powers of Chloride of Ammonium are well known, and have led to its extensive employment, especially in Germany, in cases of sore throat and bronchitis, attended with abundant secretion of thick and tough mucous or phlegm. Physicians will at once appreciate the great advantage to their patients of the local effects of this salt slowly dissolving and coming in direct contact with the inflamed surface. It at once mitigates the cough or irritation, and lessens expectoration. Two or three of the Tabloids will sometimes entirely relieve coughs that have long resisted treatment with ordinary remedies. One may be dissolved occasionally on the middle of the tongue, not near the tip.

Supplied in bottles, at 6d. and 1s. 6d. each.

Sal Prunella Tabloids.

"A popular remedy, sometimes successful in mild cases of incipient inflammatory sore throat, is a small piece of nitre allowed to dissolve slowly in the mouth" (Waring). An excellent saline for throat cases, having very marked local efficacy when slowly dissolved on the tongue. It is a popular remedy, and for mild inflamed sore throat its ancient reputation is deserved.

Directions.—One or more (5 gr.) Tabloids should be dissolved slowly in the mouth for the local effect.

Supplied in bottles of 100, at 1s. 6d.

Tabloids of Compressed Chlorate of Potash with Borax.

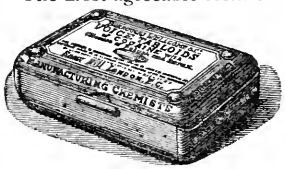
The Tabloids afford an agreeable form in which to prescribe Chlorate of Potash and Borax.

Supplied in beautifully graven white metal boxes, pink silk label, at 6d. and 1s. each.

Voice Tabloids.

Voice Tabloids contain COCAINE, CHLORATE OF POTASH, AND BORAX.

The most agreeable form in which to prescribe Cocaine is in the Voice Tabloids with Chlorate of Potash and Borax. These Tabloids clear the voice and impart to it a silvery tone.

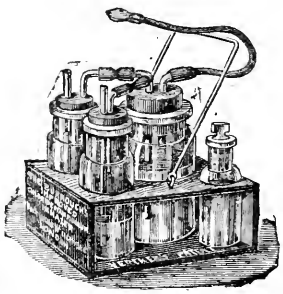


The Voice Tabloids supplied in beautifully graven white metal boxes, blue silk label, at 1s. and 2s. each.

Chloride of Ammonium Inhaler.

(VEREKER'S PATENT.)

"The vapour of Chloride of Ammonium removes unhealthy and offensive secretions, and restores the long diseased or weakened nasal and respiratory mucous membrane to a healthy state, so that in cases of catarrh, where thickening, induration and irritation exist, a most decided improvement is brought about in a short time." In "throat-cough," pharyngeal irritation, and relaxation and weakness of the throat, it acts as a most effective alterative and tonic to the mucous membrane.



The Burroughs Chloride of Ammonium Inhaler affords perfectly neutral fumes, and is always ready for use.

Dr. FRANKS, Dublin University, says:—"It is the best I have ever used, and I think I have tried all."

Dr. SMYLY, Ex-Pres. Royal College of Surgeons, Ireland, says:—"It is the best Inhaler for Chloride of Ammonium I have met with."

Price, 10s. each.

Supplied by all Chemists throughout the world.

BURROUGHS, WELLCOME & CO.,
Manufacturing Chemists,
SNOW HILL BUILDINGS, LONDON, E.C.

THE
JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. JULY, 1888. No. 7.

Contributors of original articles receive Fifty Reprints gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

ON THE DISTURBANCES OF THE FUNCTIONS OF THE LARYNX IN DISEASES OF THE CENTRAL NERVOUS SYSTEM.

By PROFESSOR DR. HERMANN KRAUSE (Berlin).

COMMUNICATIONS concerning the disturbances of function of the larynx in central diseases, more especially such as are recorded with sufficient laryngoscopical observations, are both rare and widely scattered in literature. A general review of the more commonly occurring laryngeal pathological appearances in certain groups of diseases, is especially wanted. Text-books of neuro-pathology and laryngology[1] exhibit great deficiencies in this respect. A rich harvest may therefore be expected from this line of observation, both as regards the elucidation of many controverted laryngoscopical questions, and from a diagnostic standpoint. I have always, on this account, considered it a problem of great interest, to accurately examine into the condition of the larynx in all the cases of central disease which have come under my observation. In order to carry out this line of inquiry upon a larger scale, I found opportunity to accomplish my object in the examination and observation of several hundreds of patients with various nervous affections, at the nervous and psychiatric clinic of the "Charité-Krankenhaus." As coming particularly under observation may be noted—spinal syphilis, chorea, central tumour, hemiplegia, lead-poisoning, hystero-epilepsy, epilepsy, aphasia, railway-spine, pseudo-bulbar paralysis, progressive paralysis, multiple sclerosis, bulbar paralysis, and tabes dorsalis.

Those cases which are of most interest, by reason of their contributing anything to the elucidation of symptoms already well known, are derived

[1] The Second Edition of Gottstein's Textbook is a praiseworthy exception.

from the following:—Progressive paralysis, multiple sclerosis, bulbar paralysis, and tabes dorsalis.

I may first consider, in a few words, the more uncommon pathological laryngeal phenomena, noted in the first-mentioned central lesions.

In the cases of *chorea* observed the same appearance was nearly constantly seen, viz., a trembling of the vocal cords, which sometimes were extremely weak in tension, the rima glottidis triangular in consequence of paresis of the adductors, an appearance which is seldom seen in the extremities. Peculiar choreic movements of the laryngeal muscles, as observed by others, I have never found.

In one case of *lues spinalis*, in which there was a left-sided facial paralysis, there were, in 1876, several attacks of loss of consciousness, there was great diminution of the muscular sensation in both upper extremities, especially the left; ataxia in both arms; difference in size of the pupils (but both reacted well), and the knee phenomenon. In this case the glottis was oblique, in consequence of the left vocal cord remaining almost motionless near the mid-line. A month later, after inunction treatment, the left vocal cord regained its mobility simultaneously with improvement of the paralytic condition of the left extremities.

Eight cases were observed of *lead paralysis*.

Of these, six yielded negative laryngoscopic signs. One case exhibited immobility of the left vocal cord, which remained near the mid-line. The second exhibited remarkable tremulous movements of the vocal cords, and paresis of the adductors.

One case of *cerebral tumour* came under observation, in which the autopsy revealed a teliangectatic glio-sarcoma of the corpus striatum and temporal lobe; and which, during life, had given the usual cerebral symptoms, such as right-sided paralysis and aphasia. In this case the right half of the larynx was paralysed (vocal cord in cadaveric position and relaxed). The case did not serve for accurate localization of the lesion, the tumour being too diffused, but helped, like one of pseudo-bulbar paralysis to be mentioned later, to confirm the existence of a cerebral centre for the larynx.[1]

In hysteria, hystero-epilepsy, and epilepsy, combined with hemianæsthesia of one-half of the body, the latter extends regularly to the mucous membrane of the nose, the velum palati, the pharynx, larynx and trachea.

In one case of hystero-epilepsy occurring in my practice, in a young girl twenty-one years of age, in whom, after every attack, aphasia lasted fourteen days and longer, I found perverted action of the vocal cords, viz., approximation of the same during inspiration, gaping of the glottis during expiration and on phonation. In another case of hysteria, in a girl of seventeen years of age, one vocal cord was normal in its action, but the other showed paresis of the crico-arytenoideus lateralis muscle, and also of the thyro-arytenoideus internus, and total aphonia was present. In spite of the apparently sufficient activity of the vocal cord, the same could be caused to diminish by any manipulation of the

1 H. Krause: "Ueber die Beziehungen des Grosshirnrinde zu Kehlkopf und Rachen." Archiv f. Physiologie, 1884, Heft 3.

pharynx or larynx, such as the introduction of the mirror, or electrization of the neck, or through the head, but returned regularly after a few minutes. At last I made the patient read aloud for an hour, after a return of the voice, and the voice and speech subsequently remained permanently loud; the left vocal cord, although always still paretic, is now adducted with more power. In this latter case, I am of opinion that there must be a functional disturbance of the expiratory muscles, as well as paresis of the left vocal cord, which does not permit the expiratory air to be emitted under pressure strong enough to render the relatively sufficiently active vocal cord tense.

Here may be mentioned the anæsthesia of the larynx in *railway spine*.

In a case of this kind, in which occurred total anæsthesia of the skin (with the exception of a few spots), the sternum, the vertebral column, the scrotum and penis, and the ulnar sides of the arms, the cornea reacted very slowly, and the patient stated that he never felt the stimulation. This subject also presented anæsthesia of the tongue, with the exception of the tip; also of the palate and posterior pharyngeal wall (patient can swallow the hottest soup without any sensation of temperature, although other patients can scarcely hold it in the mouth). Reflex excitability is retained in the larynx, but is very much deadened. On stimulating with a probe, the glottis is slowly closed, and breathing inhibited, only this inhibition of respiration troubles the patient, but he possesses no feeling. A second case exhibited precisely the same symptoms.

Two cases of *pseudo-bulbar paralysis* are noted. In one the examination was negative; in the second the right vocal cord lay, on gentle breathing, nearly completely against the side of the larynx. On phonation the cord was only moved from this position with very great effort, and adducted a little to the outer side of the cadaveric position, afterwards returning instantly into the former position. The right vocal cord remained motionless in the cadaveric position (the left extremity was also paralysed). At the autopsy several disseminated spots were found in the medullary substance of the brain.

Of four cases of *aphasia* only one exhibited anything noteworthy. In a lithographer, fifty-two years of age, who besides aphasia presented a right-sided facial paralysis, within the five weeks during which he was under observation, a marked impairment of mobility could be observed in the larynx. On the 15th September, the day of the first examination, there was only found a moderate degree of adductor paresis—the crico-arytenoideus lateralis and transversus of the right side; besides anæsthesia of the right side of the pharynx and larynx. On the 20th October the essential muscles of the vocal cords—the thyro-arytenoidei—of both sides were paretic, so that in laborious phonation the false bands were thrown into vicarious vibration, and the right vocal cord disappeared nearly completely under the false cord. At the same time there was a considerable deepening and dulling of the voice and speech. This case should have a certain significance, since observations of this kind up to now have, so far as I know, failed to assist our knowledge of the localization of such lesions. I may also here remark that, according to the nature of the lesion, one

cannot expect complete aphonia but merely weakening or deepening (Vergröberung) of the voice.

I come now to those diseases which, on account of their greater frequency, have presented a correspondingly more copious supply of material, and which exhibit some phenomena in common.

In *progressive paralysis* the commonly observed nasal speech appears to be dependent on a more or less considerable paresis of the velum palati, according to its length of duration and intensity. The reflex excitability of the same appears to me to be reduced, as a rule; but in psychical conditions I cannot emit any opinion as to the sensibility. The deepening of the voice, which is often observed in the beginning of the disease, may be occasioned by certain laryngeal muscles becoming paretic, and most especially the internal thyro-arytenoidei. In later stages, the movements of the vocal cords on phonation are seen scarcely to approach the mid-line farther than the cadaveric position. If greater effort is used the vocal cords spring back again into the respiratory position. They therefore appear to be strongly excavated at their edges, thin throughout and atrophied. Now and again (but this is very seldom) one meets with complete paralysis of a vocal cord. In the greater number of cases we have to deal with paresis and atrophy of the adductors, whilst the reflexly acting respiratory muscles (crico-arytenoidei postici) preserve their activity unimpaired. Laryngoscopic examinations upon these patients are exceptionally difficult, and require much patience.

In *multiple sclerosis* paralysis corresponding to the general form of motor impairments seldom occur. The weakness, hoarseness, deepening or roughening (the variations in the height of the tone) of the voice, which is very commonly observed in this class of patient, is caused in certain cases by the very remarkable laxity of the vocal cords, which is to be especially ascribed to the paretic condition of the thyro-arytenoid muscles, although the other adductors do not act with full power. Disturbances of sensation, as in other regions of the body, occur but seldom. Only in one case did I notice a very marked and complete anæsthesia localized upon the lingual surface of the epiglottis, whilst the rest of the larynx and the pharynx retained normal sensibility.

Progressive bulbar paralysis and tabes dorsalis yielded the most abundant results. In both affections the conditions are very variable. Sometimes it is the case that there is such a high degree of destruction of function in the larynx that the symptoms are extreme (laryngeal stenosis, continuous paroxysmal cough, laryngeal spasmodic attacks) and threaten the life of the patient.

Progressive bulbar paralysis, in most cases, is accompanied with unilateral paresis or total paralysis of the soft palate, the pharyngeal constrictors, and the laryngeal muscles, and with disturbances of sensibility. But sometimes there occurs unilateral or bilateral persistent median position of the vocal cords, which has been designated by Gerhardt, "posticus paralysis"; but which I have proved experimentally to be due to peripheral lesions, and in a great number of cases caused by spastic contraction of the adductor muscles.

A case which is of special value as a proof of this opinion was observed

by me at the nervous clinic. On the 9th May, 1885, a patient came under observation, aged forty-four, who had, nine years previously, acquired syphilis, and had experienced four years previously pains, numbness and weakness in the right upper and left lower limbs, with shooting pains in the neck. The symptoms being gradually aggravated, and walking becoming impossible, the patient, at the end of January of the same year, while standing out of bed, without previously suffering from his old pains, or from hoarseness, was quite suddenly attacked with a feeling of intense constriction in the neck, which was so great that he was placed on a sofa by his wife, in the expectation of falling down. The intense respiratory difficulty lasted uninterruptedly for some moments. The patient at the time showed the following symptoms: Saddle nose, unequal pupils, slight ptosis of the left side, sensation of pressure in the cervical region, no sensory disturbance, weakness and stiffness in both legs, cyanosis of the lips and ears, stridulous inspiration, and long drawn easy expiration. The laryngeal mucous membrane, with the exception of slight reddening of the posterior wall, was quite normal. The vocal cords remained, during inspiration and expiration, completely immovable and strongly tense in the middle line, leaving a space of one millimetre between them. It was very remarkable, that in spite of the great tension of the vocal cords, these could not phonate, but that on attempts at phonation, the aditus laryngis was so greatly narrowed in sphincter fashion, that the vocal cords were completely covered, and the false bands were thrown into vicarious vibration by the expiratory current of air. In consequence, there was produced a toneless, rough, whispering voice. The velum palati was paretic. Articulation was good. In consequence of pneumonia succeeding and increased dyspnœa, tracheotomy was necessary on the 12th of March. The patient died the next morning. The following were the essential points revealed at the autopsy. On the inner surface of the frontal bone, and both parietal bones, there was great hyperostosis, with here and there loss of substance. The brain showed in section marked vascularization of its anterior circumference. In the neighbourhood of the lower end of the medulla oblongata there was great thickening of the spinal dura mater, with firm adhesions with the arachnoid in the neighbourhood of the cerebellar fissure especially. There was a very thick growth on the lower part of the floor of the fourth ventricle firmly fixed. This thickening of the dura mater continued downwards, forming adhesions with the pia mater, and only gradually ceased in the lumbar region. The pons, the pyramids, and the contiguous parts of the spinal cord were markedly flattened. In the pyramids grey fibres were continued into the decussation. The orifice of the central canal was apparently closed, and under the decussatio pyramidum were excavations, &c. The diagnosis was made of Pachymeningitis et arachnitis adhesiva spinalis; Myelomalacia flava cystica regionis cervicalis; Degeneratio grisea partialis medullæ spinalis: Pachymeningitis pseudomembranacea cerebri convexitatis levis chronica. Pachymeningitis externa spinalis. Multiplex gummosa. Pneumonia fibrinosa duplex. Hyperplasia levis lienis; cicatricea præputis et glandis.

An examination of the organs concerned was not made. However

I believe that we can come to a sufficiently safe conclusion from the already quoted appearances.

Firstly, the suddenness of the onset, and the uninterrupted continuation of intense dyspnœa, as well as the uncommonly rigid tension of the vocal cords, undoubtedly indicate a contraction of the whole adductor muscular system. Decision can only waver, as it appears to me, between a spastic or a reflex contraction. The onset and the persistence of the contraction are probably explained by an apoplectiform injury of the vagus-accessorius nuclei. If we adopt the view of an irritative contraction, we can only conceive the accessorius as implicated. If we take the view of a reflex contraction, this is quite explained by the conception of a lesion of the nucleus of the superior laryngeal nerve, this stimulation leading reflexly to a closure of the glottis. If one or other of these assumptions be right, the condition is better explained than the adoption of the theory of a paralysis of the abductors—crico-arytenoidei postici—and a contraction of the adductors succeeding to this.

In *tabes dorsalis* motor disturbances of the vocal cords occur in such variety and frequency that they cannot be regarded as uncommon accompaniments of this condition. I have found disturbances of the functions thirteen times in thirty-eight cases. Most of these were in the later stages of the disorder. If this relatively small number of cases cannot lead us to any general conclusions, especially since the cases observed were in part selected on the supposition of coincident laryngeal implication, it clearly demonstrates that this organ is frequently involved in tabes.

The fact that such laryngeal conditions remain so frequently undetected is explained on the ground that they seldom lead to interference with the vocal functions. As an instance of this, I have observed at the clinic for nervous diseases, a tabetic subject, whose right vocal cord was paralysed and in the cadaveric position, but whose singing voice was so relatively little affected, that he could actually give singing lessons. The voice of this man was only little rough, and somewhat high pitched ; in singing he always took the high tones in a powerful falsetto, a vocal register which, as we know from the researches of Joh. Müller and Oertel, requires only the vibration of the edges of the vocal cords, whilst the other part of these vibrates inactively. We find in tabes pareses and paralyses of the vocal cords of all kinds, which sometimes show the peculiarity that at short intervals they come and go or improve and recur. I have seldom noted disturbances of sensibility. The most remarkable phenomenon is the occurrence of true ataxy of the vocal cords, which had already been noted in one case by Krishaber. This was exhibited in one case by to-and-fro movements of the vocal cords, of such a kind that they would suddenly approach and remain half-way towards the adductor position, and then suddenly would come together into the median position. The same occurred by the return into the inspiratory position. The result was, that the patient, while in the middle of speaking some words in a thick voice, would suddenly drop a word. Another time the ataxia was of such a nature, that without a large consumption of expiratory air, the vocal cords were driven together with great force, and then recoiled

into the most extreme inspiratory position. The similarity of these motor anomalies of the vocal cords with the irregular periodical contractions of the ocular bulbs on approaching objects to the boundary of the visual field, gives them a similarity with Friedreich's "ataxic nystagmus."

In regard to the *laryngeal crises*[1] occurring in tabes, I have had the opportunity of observing three cases of this nature. In the first patient the attacks, whether spontaneously or artificially produced, began with a sensation of tickling in the neck (which also lasted beyond the time of the attack), with spasmodic cough, choking, and expectoration of mucus, breathlessness, and stridulous crowing inspiration; and the attack ended with increased impediment to breathing, and complete spasm of the glottis, which was slowly relaxed. Various manipulations would induce the attacks; and, most easily of all, a slight pressure upon the thyroid cartilage, and on the crico-thyroid membrane, at the point of entry of the superior laryngeal nerve, or pressure upon the trachea just below the larynx; also by stimulation of the pharynx with a probe, and of the sinus pyriformis of the larynx and nose. Based on these experiments I have followed Gerhardt's example of brushing the interior of the larynx with cocaine, which has had the effect of diminishing the intensity and frequency of the attacks. Sometimes these attacks disappeared entirely, but returned soon, although with less intensity. Laryngoscopically, permanent adduction of the vocal cords was found, the width of the glottis being $\frac{1}{3}$ centimetre, with small excavation of the edges of the vocal cords, especially the right one. After the use of cocaine the widening of the glottis was incontestable.

In two other patients—one a man forty-nine years of age, the other a woman of thirty-two; who, likewise had laryngeal crises—these could also be produced artificially by stimulation with a probe. In the man gastric crises also occurred, following on previous sudden asphyxiative attacks, which consisted of violent coughing fits, interrupted with inspiratory stridor. Latterly these have been repeated with diminished intensity. In these patients there was also often noticeable, during sleep, noisy inspiration. Pressure upon the inner side of the sterno-mastoid muscle, between this and the larynx, caused intense pain. The patient stated that he now frequently experiences, especially in the mornings, a sensation of tickling and stabbing in the neck, with a feeling of pins and needles in several spots, and hawking without the least expectoration. The slightest irritation of a probe in the larynx is followed by a severe attack of spasm of the glottis, which is accompanied with vomiting of masses of greenish mucus. The feeling of dyspnœa is so great that the patient is obliged to keep himself from falling. He is compelled also to continually swallow, although he feels the previous stimulation with the probe remain, as if he was pricked with a piece of holly. The attack ends in excessive hawking and a short spasm of coughing. In both these patients the laryngoscope revealed a gradually increasing (during the time they were under my observation) adduction position of the vocal cords, which left a glottis

[1] I have proposed to use the term, "*laryngo-spastic attack*," instead of the words, "*laryngeal crisis*.

scarcely wider than two millimetres. I must here conclude without recording a large number of other cases which have been under my observation, reserving these for appearance later on in a larger work.

FOOD AND THROAT AFFECTIONS.

By Ephraim Cutter, M.D., LL.D., F.S.Sc., Lond.

Early I found that catarrhal throat affections were not cured in my hands unless the patients were well fed. For example, pharyngitis sicca yielded when the patients, in addition to local applications, drank freely of hot water, and ate two mouthfuls of animal food to one of vegetable food (the normal proportion as laid down by Dr. Salisbury),[1] which I recommend from experience. This work teaches that catarrhs come from improper feeding; that is, from food which ferments in the alimentary canal, forming carbon dioxide and other gases, alcohol, acetic acid (vinegar), butyric acid, &c. The carbon dioxide is the most active in producing throat and other catarrhs by its more or less complete paralysing action. Perhaps the catarrhs of the intestinal mucous membrane are the most common, and the morphology of the fæces shows their presence in the shape of a ropy, adhesive, copious mucus called "colloid" by our author. So the ropy, adhesive, sticky, gelatinous mucus of the throat, is the product of the secreting epithelia, partially paralysed by the carbon dioxide before mentioned. In the early stages of throat catarrh, the mucous membranes are thickened and hypertrophied. The follicles are enlarged, and the quantity of secretion is copious, made up of a jelly-like protoplasmic matter, sometimes clear, sometimes bluish, sometimes in ovoid or globar masses ("colloid") with mucous cells, many of them distended to a giant size by albuminoid matters, by granular crystalline matters, or by melanotic and pigment matters. Sometimes the mucus is in threads, filaments, skeins, straight, wavy, or twisted in spiral curves or curls, according as it is more or less adhesive. After the catarrh has become chronic, a thin blanched, pale, ashy condition of the mucous membrane occurs, which spreads to the sub-mucous tissues, so that you find the throat as if scraped out with a curette and excavated. If there is redness, it is from the passive congestion of the weakened and paralyzed blood-vessels, which topical applications fail to contract, and which section by scarification only relieves in so far as the vasomotor nerves are so paralyzed that they fail to respond to local stimulants and tonics.

If the connection of the tongue is conventionally recognized as valid, then it is but a step farther to connect the whole throat with the alimentary canal; but we have something more positive to offer than opinion, and we quote the throat symptoms that were noted in healthy men selected from a large number of labourers, hired to live on oatmeal and a diet containing vinegar in excess.

[1] *The Relation of Alimentation to Disease.* By J. H. Salisbury, A.M., M.D., LL.D. J. H. Vail & Co., New York, 1888.

OATMEAL.[1]

Four men were made to live exclusively on oatmeal porridge; on the—

Thirteenth day—There was a choky feeling in swallowing in two of them.

Fourteenth day.—Mouth and throat covered with sticky mucus in two.

Fifteenth day.—Ditto, ditto, in two.

Sixteenth to twenty-fourth days.—Throat and fauces dry and sticky in three.

Twenty-seventh day.—Voice weak; thick and husky; fauces thick, sticky. Mucus in all four.

Twenty-eighth day.—Symptoms of the twenty-seventh day intensified.

Thirtieth day.—Cured by beef diet, begun this day.

DIET WITH VINEGAR IN EXCESS.[1]

Four men, labourers, selected from 100 that offered for experiment.

Third day.—Watery secretion in fauces of two subjects.

Fourth day.—Fauces congested and watery in three.

Fifth day.—Man (A), Fauces watery, sneezing. Man (B), appears as if he had taken cold. Man (C), Fauces watery and congested. Man (D), throat watery.

Sixth day.—(A), Fauces congested and watery; hacking cough at times. (B), Ditto. (C), Fauces congested as with a cold, and watery; scalded sensation in throat. (D), Fauces congested and watery; hacking cough.

Seventh day.—(A), Throat congested and watery; scalded and sore feeling in throat; coughs and expectorates tough mucus. (B), Fauces hot, watery, and congested, with a scalded feeling.

Eighth day.—(A), Throat congested as with a cold; has a scalded feeling with dysphagia; cough quite severe at times. (B), Throat congested; has a scalded feeling, making it painful to swallow at times. (C), Throat hot, congested and watery as with a cold; hurts to swallow; coughs severely at times. (D), Throat has a scalded sore feeling that makes it difficult to swallow at times.

Ninth day.—Experiments discontinued as too dangerous.

The history of cases fed on food that did not ferment but was properly assimilated and appropriated to the building up of the whole body shows marked improvement and cures, even when there were organic lesions, and demonstrates the importance of combining systemic with local treatment. The subject is so rich that we can only make a few suggestions for others' thoughts.

1. In topical treatment, as the late lamented and beloved Dr. Louis Elsberg used to say, we simply arouse a local disturbance, and shake things up in the hope that nature will be able to settle down matters in a normal way. As in the outside world after a thunderstorm, so it is nature that cures in our topical applications. This is correct.

2. But if we allow the causes to persist (*i.e.*, fermenting food), it is not long ere another local shaking up is needed, and hence we have a persistence of the disease—scotched but not killed.

[1] *Op. citato.*

3. If we remove the prime cause (*i.e.*, fermenting food), and build up the body system with food that nourishes normally, the *vis medicatrix naturæ*, we may then stir up things by topical applications, and expect permanent relief as the causes are removed and vital force restored, so that things will remain settled, and thus lead to a permanent cure.

For an average case the diet may be as follows, if one chooses (*op. citato*):—

1. Food from the animal kingdom—beef, with mutton for a change.

2. Food from the vegetable kingdom—bread, cracked wheat, rice, potato, sago, hominy, tapioca, one each at each meal; hot water, one pint one hour before meals and on going to bed; tea and coffee with cream, no sugar; pepper, butter, salt, horseradish, celery, and lemons for relishes.

Bear in mind that any food that digests perfectly in a person is a good food for that individual. Allowance must be made for idiosyncrasies. No food is a good food that ferments and digests badly. The spontaneous disappearance of growths from the larynx is explained by an improvement in digestion. I recollect such a case in a man over seventy, where the growth was about the size of an oat, and situated on the right vocal band.

NEW INSTRUMENTS AND THERAPEUTICS.

ALRATH (Sunderland).—**On the Use of Elastic Canulas instead of Silver Canulas in Tracheotomy and Hæmatherapy.** *Wiener Med. Wochenschr.*, 1888, *No.* 15.

CONTENTS indicated by the title. **Michael.**

LARDY (Berne).—**Canula for Deep Circumscribed Stenosis of the Trachea.** *Monatschr. fur Polytechnik*, No. 6, 1888.

THE lower part of the König canula is movable and can be altered by a steel band. It is thus possible to manipulate it so that the injured part alone is dilated. It has been used in one case with good results.

Michael.

F. X.—Respiration in Winter.—*La Gazette Médicale de Montréal, February*, 1888.

IN a short article F. X. recommends breathing through the nose when possible. When the use of the mouth is necessary, he suggests pressing the tip of the tongue against the hard palate at its junction with the central incisor teeth. This is a very old popular plan.

George W. Major.

BARATOUX (Paris).—**Stimulating Gargle.** *La Pratique Médicale, May* 22, 1888.

℞	Borate of Soda	10 grammes
	Aq. Menth.	50 grammes
	Glycerine	20 grammes
	Distilled Water	200 grammes

R. Norris Wolfenden.

WEIL, EDMOND.—Carbonic Acid in the Treatment of Certain Forms of Dyspnœa. *La Prat. Méd., May* 8, 1888.

PATIENTS are made to inhale carbonic acid with the Limousin apparatus. The sittings last two to four minutes, and the dose of carbonic acid varies from two to four litres at each inhalation. They are ordered once or twice a day. No ill effect has ever been observed, but just the reverse. Patients so treated were tubercular, and most with laryngitis and advanced lesions of the lungs. Dyspnœic attacks were cut short by the inhalations, and a sense of well-being obtained. If the inhalations were made in the intervals between the attacks, the first effect was characterised by freer respiration ; more carbonic acid had a preventive action on the paroxysms, diminishing their frequency, intensity, and duration.

The same success has attended the treatment of attacks of dyspnœa in albuminous emphysematous patients. The action of these inhalations can be compared to injections of morphine for pain. The inhalations are constantly followed by abolition of reflex sensibility of the pharynx and larynx, but not by any modification of cutaneous sensibility.

R. Norris Wolfenden.

YERSIN, A.—The Action of some Antiseptics and of Heat upon the Tubercle Bacillus. *Annales de l'Institut Pasteur*, 1888. *Rev. Med. de la Suisse Romande, May*, 1888.

THE author has arrived at the following results :—

	Thousandths.	Germs not all killed.	Germs all killed.
Phenic Acid	50	—	30 seconds
ditto	10	—	1 minute
Absolute Alcohol	1,000	—	5 minutes
Iodoform in Ether	10	—	5 minutes
Ether	1,000	5 minutes	10 minutes
Bichloride of Mercury ...	1	5 minutes	10 minutes
Thymol	3	2 hours	2 hours
Water saturated with Creosote	—	1 hour	—
ditto ,, ,, Naphthol β	—	1 hour	—
Salicylic Acid	2·5	1 hour	6 hours
Boric Acid	40	12 hours	—

As regards temperature, a culture was obtained in glycerine bouillon after heating the bacilli to 55° for ten minutes. When heated to 60°, a culture was obtained after twenty-two days. Those heated to 70° gave no further development.

R. Norris Wolfenden.

RAOULT, A. (Paris).—**The Dangers of Antipyrine.** *Progrès Médical, May* 26, 1888.

ANTIPYRINE has been known to cause gastric pains, fright, contortions, eruptions of urticaria accompanied with itching. The patient has lost consciousness. A lady (related by M. Bell) who took 2 gr. 50 of antipyrine in one dose, for rheumatism, experienced tumefaction of the face, which became red, the pupils swollen and almost entirely closed. The rash invaded the limbs, at first as reddish *taches*, then becoming confluent. Slight itching was complained of. Next day there was conjunctivitis, the pulse, normally thirty-five, mounted to seventy; temperature was lowered, and the patient experienced a sensation of cold. The eruption disappeared after administering a small dose of tincture of belladonna.

Similar cases have been observed after administration of doses of twenty-five centigrammes to one gramme (Allen Sturge, Whitehouse, Barbes). An urticaria like mussel-poisoning resulted. Hardy has related a similar case; and Meyer also (in the latter case three grammes had been taken). Germain-Sée thinks these accidents are rare, and have not the gravity attributed to them. He has seen urticaria only in one case out of fifty. It is more frequent in the female. Daremberg has seen this rash in tubercular patients taking antipyrine. After a certain length of time patients exhibit an intolerance of antipyrine; at the least dose a rash supervenes, and the drug has to be discontinued. It can then be replaced with advantage by acetanilide. In the case of a typhoid patient, Peter saw antipyrine give rise to epistaxis, and the patient died of cachectic purpura, and adynamia.

In another case uræmic eclampsia occurred. Probably these accidents would have occurred without antipyrine. Probably all these, and other accidents, are to be attributed to impurity in the preparation of the drug and to its containing benzine. **R. Norris Wolfenden.**

LONEY, D. W. (Olena).—**Naphthol in Stomatitis.** *Med. Record, June* 16, 1888.

"THIS is indicated in any case of stomatitis or sore throat where a reliable antiseptic and disinfectant is indicated, and has the advantage of being not unpleasant in taste and non-poisonous in its effects." It may be used for the mouth and throat as a wash or gargle, and in weak spray for nose, or as a douche. **R. Norris Wolfenden.**

DIPHTHERIA.

PAQUET, HON. DR.—Diphtheria, a Clinical Lecture at the Hôtel-Dieu. *La Gazette Médicale de Montréal,* 1887.

THE lecturer, in addition to the ordinary hygienic and local treatment, recommends benzoate of soda in 2 grain doses every two hours.

George W. Major.

D . . . . .—Notes on Diphtheria. *La Gazette Médicale de Montréal*, 1887.

THE author deals with the subject in general terms. In addition to supporting tonic and antiseptic treatment he recommends cauterization with perchloride of iron (60 grs. to ℥j), nitrate of silver (60 grs. to ℥j), and chloride of zinc (30 grs. to ℥j). He also suggests emetics to detach (*détacher effectivement les concretions et prévenir leur renouvellement*), and prevent the return of exudation. The latter remark has reference to pharyngeal diphtheria, and is certainly of a questionable character.

George W. Major.

JENNY (St. Gallen).—**On Conditions Consecutive to Tracheotomy for Diphtheria and Croup in Children.** *Dtsch. Zeitschr. für Chir.* Bd. 27, Heft 5.

REPORT on 214 cases of tracheotomy performed in the Hospital of Münsterlingen, 95 cases were cured, 44 per cent.; 119 died, 56 per cent. Inferior tracheotomy was executed in 95 cases, with 45 cures. The prognosis was better if no membranes were coughed out, and if the temperature of the disease was less than 39° Celsius. In 5 cases the canula could not be removed before the twentieth day after the operation because of granulations in the trachea. One of these cases died from suffocation. The greater number of the children operated upon had cough, hoarseness, and slight dyspnœa for some months afterwards. Secondary diphtheritic paralysis was noticed in 27 cases. Recurrence of diphtheria and secondary tracheotomy in three cases.

Michael.

OERTEL (Munich).—**The Patho-Genesis of Epidemic Diphtheria in its Histological Relations.** With 16 Tables. *Leipzig*, 1888.

VERY important work by the well-known professor on the histological processes in diphtheria, the anatomy and pathological physiology of the pseudo-membranes in primary and secondary diphtheria. It is not possible to give in a report a correct summary of the contents. The study of the original work is recommended.

Michael.

RIEMER (Leipzig).—**On Diphtheria.** *Festschrift für E. L. Wagner, von seinen Schülern. Leipzig*, 1888.

THE author believes that diphtheria is a contagious disease, but that only individuals pre-disposed to it are attacked. For treatment he uses turpentine.

Michael.

BOYD, J. M. (Knoxville).—**Some Clinical Observations on Diphtheria and Veratrum Viride as the Basis of Treatment.** *Med. Rec., June* 9, 1888.

THE early and decided use of veratrum as the basis of treatment offers promise of better results in diphtheria than any other plan. To slow the pulse should be the *sine qua non.*

The severity of the attack may be better measured by the pulse rate and tenseness than by any other symptom. To reduce the circulation is

to reduce the intensity of the inflammation. Asthenia is not to be feared in veratrum, but rather exhaustion from continued rapid heart action. The best treatment is rest, by slowing the heart.

The throat should be locally treated by mopping the membrane with liq. ferri. sub. sulph., 1 drachm; glycerine and water, 4 drachms each; and the following mixture should be administered—a tablespoonful of saturated solution of potass chlorate, with three drops of Norwood's tincture of veratrum, every two hours; the veratrum to be increased one drop if necessary each time, until the pulse is brought down to 60-70 per minute. After each dose sublimed sulphur (8 grains) should be swallowed dry, or blown into the throat, and the outside of the throat should be rubbed with kerosene or other irritant. Simple nutritious animal food should be given.

R. Norris Wolfenden.

RAYMOND, J. H.—History of Diphtheria; its First Appearance in Brooklyn in 1854. *Brooklyn Med. Journal, May*, 1888.

HOMER (1,000 B.C) and Hippocrates (460 B.C) knew the disease, and it was known as Malum Ægyptiacum. Aretæus, who described it in 100 A.D., believed it to originate in Syria and Egypt. In past times it has been known by the terms ulcus Syriacum, ulcus Ægyptiacum, garotillo, morbus suffocans, angina maligna, &c. It was epidemic in imperial Rome A.D. 380. From the time of Œtius (fifth century) to 1557, when it appeared in Holland, nothing is known of it. In 1563 it was epidemic in Naples and Sicily, and in Constantinople in 1564, and in Paris in 1576. Spain was heavily visited from 1582 to 1613; Germany in 1565, and Portugal in 1626 was also visited. In 1659 it appeared at Roxburgh (Mass.) and was prevalent in various parts of New England. In 1735 an epidemic began, which spread from Kingston (N.H.) through all the British colonies. An epidemic occurred in Paris in 1745, in England in 1744, and in Switzerland (the first) in 1752, in Holland in 1747, and Sweden in 1755. In 1769 it existed at Jamaica. In 1818 a severe epidemic appeared at Tours, in France, which was carefully studied by Bretonneau, who called it diphtheritis (from the Greek diphtheria, skin). Trousseau changed the name to diphthérie, which was anglicised by the Registrar-General of England into diphtheria. In 1826 an epidemic occurred in Edinburgh, in 1853 it prevailed in Paris, in 1855 in Boulogne, and from here it was imported into England in 1856, assuming alarming proportions in 1858, 1859, 1860, 1861, and 1862. The first case occurred in New York in 1852, and in Brooklyn in 1854. It is now among the most prominent causes of mortality in the latter city.[1]

R. Norris Wolfenden.

MASON, L. D.—The Local Use of Permanganate of Potash in Nasal and Pharyngeal Diphtheria. *Brooklyn Medical Journal, May*, 1888.

PLACING the patient in an atmosphere charged with steam will prevent secondary and tracheal and pulmonary complications, and will facilitate

[1] In 1887 there occurred 383 cases of diphtheria in Brooklyn, with 168 deaths. In 1888 there were 803 cases, with 324 deaths. The estimated population in 1888 was 774,870.

throwing off the exudations. Pure fresh air is essential. Sprays of permanganate of potash (3ij. to ℥iij. of distilled water; 3j. in 3p.—℥ij. of water) have been most serviceable in the author's hands. Mouth washes and gargles may also be used. It is a germicide and deodorizer. The spray should be continued until all trace of exudation is removed.

R. Norris Wolfenden.

MOUTH, TONSILS, PHARYNX, &c.

KÜSTER (Berlin).—**On Neoplasms of the Upper Jaw, and the Result of their Operative Treatment.** *Berlin Klin. Wochenschr.*, 1888, *Nos.* 14, 15.

OF thirty-eight cases operated on, eleven are definitely cured. Of sarcomas and fibromas, four by partial, five by total extirpation. Eight patients died from the operation. Of these, five cases were carcinomata, two sarcomata, one naso-pharyngeal polypus. One patient suffering from polypus, and one from carcinoma, are living with recurrence. All the others died from recurrence. The author gave a detailed description of the steps of the operation, and hoped that the results would be better if the neoplasms were operated upon at a very early stage. To prevent the loss of the eye, which frequently follows the operation, the author advises that the orbital plate should be spared if possible, and the eye be closed by sewing the eyelids. Michael.

POTTER, F. H. (Niagara).—**Notes on the Treatment of Acute Tonsillitis in Children.** *Buffalo Med. and Surg. Journal, May*, 1888.

FIRST keep down temperature; this is to be done with antifebrin. Bicarbonate of soda should be applied to the tonsils in powder, or solution (ten grains to the ounce, sprayed by an atomiser), or by touching the tonsils with it. This local treatment should be used at intervals of an hour during the day.

[The use of bicarbonate of soda in tonsillitis was first rationally indicated by a Spanish physician. Being so simple a remedy I was induced to try its efficacy at my clinic at the Throat Hospital, and I met with such good results, that I have abandoned all other methods of local treatment. For a long time past I had been accustomed to order patients suffering from tonsillitis to rub the pure powder of bicarbonate of soda very frequently over the tonsils. I have found that this plan produces immediate relief to the patient. Slight cases of tonsillitis subside at once, within twenty-four hours; more severe cases, in which there is much tension, swelling, and pain, are greatly benefited, the inflammation, tension, and pain subsiding rapidly, without proceeding to suppuration. If the inflammation has

reached the stage of abscess formation, the suppurative process is expedited, and the application of the bicarbonate of soda leads to speedy spontaneous evacuation of the abscess. The treatment is most excellent for all cases of tonsillitis, with or without general medication (salicylates, aconite, etc.). That it is dependent upon the local effects of the bicarbonate of soda, and not an administration of other drugs, I proved by administering the alkali alone in a number of cases, with the very best results.]

R. Norris Wolfenden.

LEHMANN (Berlin).—**Large Congenital Cyst of the Bursa Pharyngea in a Little Child.** *Langenbeck's Archiv*, Bd. 36, Heft 1.

A BOY of four years old was shown to the author on account of a tumour in his pharynx. Behind the velum there was a tumour of the size of a walnut resembling a cyst. It was extirpated with scissors, and a honey-coloured mucous fluid exuded. The microscope showed that the cyst was lined with cylindrical epithelium, and that the wall consisted of adenoid tissue.

Michael.

ROLLAND, A. J. B.—**Granular Pharyngitis.** *La Gazette Médicale de Montréal*, 1887.

GRANULAR pharyngitis is described, and the usual methods of treatment advised. No original suggestions are contained in this paper.

George W. Major.

GUBB, ALFRED S. (London).—**Narrow Escape from Choking.** *British Medical Journal, January* 28, 1888.

THE patient was saved by tickling his fauces with a feather pen, and thereby inducing vomiting.

Hunter Mackenzie.

SOLIS-COHEN, S., Artificial Administration of Food. *Polyclinic, May*, 1888.

THERE was one method of which the author had no experience, viz., to pour diffluent foods through the nasal passages by means of a funnel, and trust to reflex action being exacted in the pharynx. When œsophageal tubes are used, soft ones are to be preferred. When the tube is to be introduced the patient sits upright, and assists by endeavours to swallow. To insure that the tube is not in the larynx, the patient is made to speak before pouring the food through the funnel. In many cases it suffices to pass the tube into the entrance of the œsophagus. A soft rubber catheter answers the purpose. If force is required to force the food down, an ordinary Hall syringe is quite as good as more elaborate devices. This method may be required after operations upon the larynx or œsophagus or diseases of the same, stricture, ulceration, or paralysis ; or it may be employed to obtain superalimentation in phthisis. In stricture of the œsophagus the tube may be tied in and left there for months. Tubes can also be passed through the stricture to dilate it, and be tied in, in such a manner that the patient can swallow normally ; the tubes being removed from time to time for cleansing. A soft rubber tube has also been passed into the œsophagus, and slit at the level of the arytenoid cartilages, the

two halves being brought out at different sides of the mouth or nose and fastened. Swallowing can be accomplished by this method. A wedge-shaped slit is made in the gastric end of the tube, to act as a valve and prevent regurgitation. Peptonised food is recommended, predigested with pancreatic extract or trypsin, and the methods of preparing the same fully detailed, according to the directions of Sir William Roberts, of Manchester.

R. Norris Wolfenden.

NOSE AND NASO-PHARYNX.

ROLLAND, A. J. B.—Acute Rhinitis. *La Gazette Médicale de Montréal*, 1887.

THIS paper treats of acute rhinitis in detail, and according to modern ideas.

George W. Major.

ZIEM (Dantzig).—**On the Best Method for Opening the Antrum of Highmore.**

THE author recommends the opening of the alveolar process through an extracted tooth, or near a tooth. As instrument he uses a drill. He has performed the operation in 227 cases, and has found in 222 cases this method the best. For injection he uses Mayer's douche. He has only operated on thirteen per cent. of his cases without finding fluid. Mickulicz' method of opening through the nose is much more difficult, and causes more pain and bleeding. If no tooth is carious he opens between two teeth.

Michael.

RINGER AND MURRELL.—Remarks on Paroxysmal Sneezing. *Brit. Med. Journ., June 16 and 23, 1888.*

THE names "hay fever" and "hay asthma" are unfortunately chosen, for the existence is now very generally recognized of a complaint presenting identically the same symptoms, but excited by causes other than the presence of pollen in the atmosphere. The sneezing paroxysms alternate with asthma, or one of them may preponderate. In both varieties we meet with cases in which there is itching of some part of nares, or inner canthus of the eye, or the eyeball, accompanied by repeated and violent attacks of sneezing and profuse watery discharge from the nose and eyes. The irritation may arise in the pharynx.

Various cases are related of idiosyncrasy with regard to pollen of certain plants, dust, drugs, and emanations from animals. The authors remark that the close connection between hay fever and intermittent sneezing, is well shown in those cases where not only pollen but other excitants induce an attack. Sunlight is referred to as an exciting cause of sneezing, and violent exercise also. A case is related, in which food seemed to be the excitant. In some cases it is difficult to assign any cause as is often the case in the allied affections, migraine, asthma, and

neuralgia. A number of cases are detailed of hereditary connection between this disorder and asthma. A number of ideal or emotional cases are referred to. The amusing case of a student is related whose uncontrollable fits of sneezing came on regularly at one of the writer's lectures on materia medica, "often in the most interesting part of an exposition of the physiological action of some new and valuable drug." . . . "He often had to resort to violent muscular exercise, such as a game of billiards, to subdue them" (!) The authors rely largely on cocaine locally applied in tabloids. Pungent inhalations, *e.g.*, strong ammonia, carbolic acid, camphor and iodine are useful in cutting short the attacks of sneezing. The authors give the palm to iodine, ordering the patient to carry a bottle of the liniment in the pocket, and to take sniffs at the onset of an attack. Pure terebene, pinol and eucalyptine, or a few drops of chloroform, or inhalations of creosote or camphor are also recommended. During the hay asthma season, the sufferer should regularly smoke a good cigar as a preventive the last thing on going to bed, or better still when he is in bed. Indian tobacco, or lobelia inflata are preferred by some patients; strong nitre papers burnt in the room are good. They should be prepared sprinkled with compound tincture of benzoin, essence of camphor, tincture of sumbul, or some preparation of stramonium. Himrod's powder is generally recognized to be useful. Black and strong coffee may cut short a paroxysm. Effervescing citrate of caffeine is often prescribed by the authors. They do not get beneficial results from nasal douches or sprays of quinine. Hazeline snuffed up the nose will abort the attack.

The next class of remedies is that which modifies the condition of the mucous membrane, and foremost is placed iodide of potassium.

Arsenic is of little use in true hay fever, but is good in paroxysmal sneezing. If polypus is present it should be removed, and hypertrophies of mucous membrane should be removed with the electric cautery. Liniment or ointment of aconite applied to a localized spot of itching will often give relief.

The cases related by the writers are interesting, as exhibiting the various and protean forms of these sneezing complaints. The indications for treatment are less interesting. In the long list of local applications, we do not find any mention of the very simple protective measure of smearing the nasal passages or throat with sedative unguents such as vaseline, or protecting the nose, mouth, and eyes with veils, cotton tampons, respirators, etc., measures which are quite as generally useful as those detailed by the authors.

R. Norris Wolfenden.

GENTH, CARL (Langen Schwalbach). — **Therapeutics of Hay Fever.** *Brit. Med. Jour., June* 16, 1888.

THE author believes that hay fever usually begins with symptoms of conjunctivitis. It is probably the case that the agent which causes hay fever first attacks the conjunctiva; under favourable circumstances (heat) it multiplies there, and then diffuses itself over the mucous membrane of the respiratory organs, perhaps through the medium of the laryngeal canal. To be effective, medication must be local, and directed to the eyes at the earliest date. The author believes instillation and bathing

the conjunctiva with sublimate solution (1 in 3,000), as suggested to him by Dr. Pagenstecher, to be the best remedy. The same solution can be applied to the throat and nose. The bathing should be commenced for a fortnight before the annual attack of hay fever is expected to come on, and should be continued through the hay fever season. The author relates one case in support of his views. **R. Norris Wolfenden.**

JOAL (Mont Dore). — **On Genital Epistaxis.** *Rev. Mens. de Laryngol.*, Nos. 2 and 3, 1888.

EPISTAXES are thus classified by Dr. Joal :—

1. Traumatic and ulcerative (falls on the head, blows on the nose, cauterizations, ulcerations of the pituitary membrane).

2. Dyscrasic (alterations in the vessels, or blood; hæmophilia, scurvy, hepatic conditions, renal diseases, arterio-sclerosis).

3. Mechanical (increase of pressure in arterial or venous system; efforts, cries, attacks of coughing, vomitings, tumours of the neck, enlargement of the right heart).

4. Vaso motor (turgescence from reflex erection of the tissue).

The last group comprises all those hæmorrhages, commonly described as essential, idiopathic, or spontaneous, and their causation is easily explained. Turgesence of the turbinated bodies leads to rupture and hæmorrhage. This tissue is capable of enlargement either from slight excitation of the nasal mucosa, of the skin, of the eye, or from psychical causes. But the most frequent cause of epistaxis occurring at the age of puberty is physiological or pathological irritation of the sexual organs. There is a correlation between the nose and the reproductive apparatus, as is seen in the influence of odours in man and animals on the genital function, and the turgesence of the turbinated bodies by the genital act, or by menstrual congestion, catamenial, &c., epistaxes, and those occurring as the result of onanism. The author brings forward many cases to support his views, and particular stress is laid upon the occurrence of epistaxes in young persons, which may be entirely due to masturbation, and which are arrested when this vice is cured.

R. Norris Wolfenden.

HOOPER, FRANKLIN H. (Boston).—**Adenoid Vegetations in Children: their Diagnosis and Treatment.** *Boston Med. and Surg. Journ.*, 1888, *re-print.*

THIS is a careful essay on the subject. The author remarks upon the slight knowledge there is of this condition amongst general practitioners, of how often children with adenoid vegetations are stupidly diagnosed to have catarrh, "snuffles," winter cough, winter cold, &c. Two years old is the average age when the trouble first begins in the author's experience, commencing with difficulty of breathing, especially at night, repeated attacks of cold in the head, and considerable nasal discharge. There is comparative immunity during the summer. Constant mouth breathing leads to stupid expression; sleep at night is never sound, and the respirations have a noisy suffocative character. During the day the child is languid or irritable; the majority of children are deaf, with stuffy or thick

voices. Headache, desire to lie down, and occasional vomiting occur very frequently in such children at school. This condition is wrongly called "migraine." Deformities of the chest succeed to this constant mouth-breathing, just as in laryngeal stenosis. Diligent examination should be made of the naso-pharynx. The growth must be removed. In very young children anæsthesia must be obtained. No one method of operating is suitable for all cases. The post-nasal forceps are best for large masses, and the surface may be curetted afterwards.

Meyers' ring-knife is suitable for some cases. The principal object of the operation being to establish free respiration, it is not necessary to remove every trace of growth. Any portions remaining after the operation will atrophy. The growths do not recur after removal. The author operates with the child in the upright position. The author rightly insists on the improvement in physique caused in children by removing adenoid growths. **R. Norris Wolfenden.**

LARYNX.

D'HEILLY.—Intubation of the Larynx in Croup. *Gaz. des Hop.*, *May* 3, 1888.

THE author has performed the operation at the Hôpital Trousseau, in thirteen cases of croup, using O'Dwyer's instruments. In all the cases the conditions were such as would have called for tracheotomy, and the author has taken by preference children under three years of age. American statistics show that intubation has five times as much success in children under two as tracheotomy. After four and a half years of age tracheotomy has the advantage. D'Heilly's youngest patient was nineteen months, and oldest four years of age. Of the thirteen cases, two were in such extreme condition that death could not be attributed to the introduction of the tube. Out of the eleven others were two cases (children of two years of age and two and a half years, respectively). The tube was retained between six and seven days. Intubation is accomplished without bleeding or wound, and is easy to accomplish. These are its advantages over tracheotomy. In case of failure by intubation, tracheotomy can still be performed. The canula is well supported. As to the complaint of wounding the larynx by the passage of the tube, it would require considerable brutality or absolute maladroitness to accomplish it. As soon as the tube is in place, an immediate change occurs in the condition of the infant. There is neither traumatic shock nor rise of temperature, and cold air does not penetrate into the lungs, a most important thing in the case of young infants. But there is a reverse shadow to this favourable picture. The tube is often occluded by false membrane, and it must then be taken out and replaced. This can always be done immediately at the hospital; but in other places it is another question.

The Americans say, indeed, that when the tube is occluded, it is expelled by coughing, and false membranes with it; but d'Heilly has not seen this occur. Another drawback, and one much more grave, is the interference with deglutition, and consequent difficulty of alimentation. This dysphagia is more pronounced for liquids; and as the child will not take solids, but craves for fluids, one cannot give the former. This dysphagia also leads to passage of alimentary products into the air passages with resulting broncho-pneumonia, which American physicians are wrong to deny, and others are equally wrong to exaggerate. D'Heilly has often found it at the autopsy; but it must be noted that it occurs quite as frequently after tracheotomy, in which deglutition is not the cause. It is probably explained in both cases by presence of diphtheria. The dysphagia can be readily overcome by feeding systematically through the nose. The tube need not be carried into the œsophagus, if the external thread is employed. Intubation appears to be indicated in—

1. All young infants, in whom tracheotomy offers such poor chance, and who bear losses of blood very ill.
2. In slight croups, in which tracheotomy is a grave operation.
3. Inversely in those toxic diphtheritic cases in which the patient is deprived of all resistance, and is incapable of supporting tracheotomy.
4. In croups secondary to measles, and which never succeed by tracheotomy, intubation offers a better chance.
5. In all cases where tracheotomy is impossible or dangerous.

R. Norris Wolfenden.

RADESTOCK (Dresden).—**Total Extirpation of the Larynx and the Suprasternal Portion of the Trachea on account of Carcinoma.** *Langenbeck's Archiv*, Bd. 36, Hft. 1.

A PATIENT, aged twenty-seven, was tracheotomized for dyspnœa. The canula could not be removed. The laryngoscope gave no positive indications, except a swelling of the regio hypo-glottica. The diagnosis was confirmed two years later by laryngotomy, and when this was performed a tumour was found perforating the cartilages, and filling the whole larynx, and the greater part of the trachea. After inferior tracheotomy, the larynx and the suprasternal part of the trachea were removed. There was no severe complication. Three days later an artificial larynx was introduced, with which the patient could speak well. The microscope showed that there was a carcinoma. No recurrence a year after. Michael.

ZEMAN (Wien).—**Case of Angio-Sarcoma of the Trachea.** *Wiener Med. Presse*, 1888, *No.* 21.

SCHRÖTTER'S well-known case, first operated on in 1867, then in 1873, and often quoted in laryngological literature, has now died twenty years after the first operation. The autopsy showed a walnut-shaped tumour situated at the fifth cartilage of the trachea. The microscopical examination showed that it was an angio-sarcoma. Michael.

NOLL (Hanau).—**Case of Dismemberment of the Trachea from the Larynx, with nearly Intact External Soft Parts.** *Cure by Operation*: *Dtsch. Zeitsch. für Chir.*, Bd. 27, Hft. 5.

A WOOLLEN handkerchief was twisted by a portion of machinery so as to cause strong compression of the neck. Dyspnœa, cough, expectoration of blood followed. Tracheotomy was performed. The trachea was drawn down and fixed with needles, but not joined to the larynx again, in consequence of this being fractured. After cure of the wound, it could be seen that the larynx was closed by cicatricial tissue. Laryngo-fissure was done, and a canula applied. Some months later the canula was removed, and the fistula closed by a plastic operation. After treatment consisted of using Schroetter's bougies. A cure resulted.

Michael.

SOMMERBRODT (Breslau).—**The State of the Larynx in Ventriloquists.** *Berlin Klin. Wochenschr.*, 1888, *No.* 14.

THE author has examined a ventriloquist during his performance, and has made the following observations. The velum was strongly retracted, the naso-pharynx was closed. During normal phonation the expiratory air-current passes through the whole glottis during the ventriloquial performance, and there is closure of both posterior parts of the vocal bands. The air-current passes through a little triangular opening lying in the anterior part of the glottis. By this closure the posterior part of the glottis cannot participate in the vibrations. This condition is so characteristic that the ventriloquy can only be diagnosed from the view of the larynx. Ventriloquising has therefore the same mechanism as the falsetto voice (see Morell Mackenzie's "Hygiene of the Vocal Organs"), and can therefore be called falsetto of the speaking voice. By this economy of air the ventriloquist is able to speak with much less respiration than the normal speaker. **Michael.**

BANDLER (Prague).—**On Acute Œdema of the Larynx.** *Prager Med. Wochenschr.*, 1888, *No.* 19.

1. Œdema of the glottis, a first symptom of disease of the kidneys. Cure.

2. Acute œdema of the right arytænoid cartilage, and of the ligam. aryepigl. dextrum, with unknown etiology.

3. Acute œdema of the larynx in variola, lasting three days.

Michael.

DEHIO (Dorpat).—**Primary Tuberculous Neoplasm of the Larynx.** *Petersburg Med. Wochenschr.*, 1888, *No.* 16.

THE patient, forty-one years old, had had difficulty in swallowing for some weeks. On the left ventricular band was a tumour, which was nearly the size of the whole band. It was greyish-coloured, and presented an irregular surface. The other mucous membrane of the larynx was reddish and swollen. The lungs were normal. As it was not possible to extirpate the tumour completely *per vias naturales*, laryngo-fissure and incision of the left ventricular band were performed. The microscopic

examination showed that the tumour was a conglomeration of miliary tubercles. Some days after the operation the patient became feverish, and the wound ulcerated. The patient died some weeks later. Autopsy could not be performed. This case shows that by a sanguinary operation, a tuberculous tumour can infect the whole organism, and that it would be better to destroy it by cauterization. **Michael.**

AVERBECK (Laubach am Rhine).—**Massage of the Larynx.** *Dtsch. Med. Zeitung*, 1888, *Nos.* 34, 35.

THE author described in detail the different methods of massage, and their application in diseases of the larynx. He recommended massage for nervous disturbances of the larynx, passive hyperæmia of the brain, inflammatory conditions of the organs of the neck and carcinoma laryngis(!) **Michael.**

ONODI (Buda Pesth).—**Contribution to the Knowledge of the Innervation and Paralyses of the Larynx.** *Monatschr. für Ohrenheilk.*, 1888, *No.* 5. (With a Plate.)

SEE report of the sixtieth meeting of Natural Sciences in Wiesbaden. **Michael.**

SCHÜLLER (Berlin).—**Treatment of Cicatricial Laryngo-Stenoses.** *Berlin Klin. Wochenschr.*, 1888, *No* 14.

REMARK upon Liniché's essay. (In No. 6 of this Journal.)

GAREL, I.—Specific Perichondritis simulating an Acute Œdema of the Larynx and Coincident with a Laryngeal Polypus. *Ann. des Mal. de l'Oreille, June*, 1888.

A WOMAN of 42 took cold and felt pain in the larynx, in phonation or deglutition. Five months after this had increased, and six months after there was absolute aphonia. Seven months after there was intense dyspnœa. There was œdema of the left arytenoid and left ventricular band entirely hiding the left vocal cord. Scarifications were made.

A month later a small tumour was removed from the anterior commissure, which proved to be a fibro-myxoma. Under anti-syphilitic treatment the patient got rapidly better. **R. Norris Wolfenden.**

NECK, &c.

HENNES. — Congenital Excrescences of the Neck. *Archiv für Kinderheilk.*, 1888, p. 451.

DESCRIPTION of a case. A boy nine years old had an excrescence on both sides of his neck of 2·5—3·5 centimètres in size. They were extirpated.

The specimens were covered with normal skin and had a cartilaginous centre. In an extensive embryological and anatomical essay the author describes the nature of this teratoma. **Michael.**

BILLROTH (Vienna).—**Scirrhus of the Thyroid Gland.** *Wien. Med. Wochenschr.*, 1888. No. 20.

I.—PATIENT, 46 years old, had had trouble in deglutition for some years, so that she could only take fluids. On the left side of the neck near the larynx was a tumour like a pea-nut of cartilaginous hardness. It was possible, with great difficulty, to introduce an œsophageal probe. By an operation it was possible to remove the tumour consisting of the indurated thyroid gland, but it was not possible to remove the other indurations deeper than the sternum. After the operation the patient could swallow better, and the œsophageal tube could be more easily introduced. Recurrence a short time afterwards.

II.—Unmarried girl, 26, had same difficulty in deglutition and also hoarseness. There were tumours of cartilaginous hardness on the neck near the larynx, surrounding the œsophagus. Removed by operation. Death from hæmorrhage. Examination of the specimens of the two cases showed there was a scirrhus of the thyroid gland. The prognosis was very unfavourable ; treatment can only consist of very early extirpation of the gland. **Michael.**

REPORTS OF SOCIETIES.

Royal Society of Physicians in Vienna.

Meeting, May 11, 1888.

WEINLECHNER showed two patients with hydrops and empyema of the antrum of Highmore. Both were operated upon by the method of Mikulicz with good results. **Michael.**

Medical Congress in Hamburg.

Meeting, May 1, 1888.

FRÄNKEL, E., showed some specimens of goitres, such as paralysis of the recurrent nerve and deformities of the trachea. He recommended treatment with iodide of potash, brushing with tincture of iodine, and ice externally. **Michael.**

Seventh Congress of Internal Medicine in Wiesbaden.

Meeting, April 9, 1888.

V. JÜRGENSEN (Tübingen) on *crypto-genetic, septic pyæmia.*

THE author described a great many cases of crypto-genetic septicæmia. This is an acute sepsis producing deleterious process in most of the organs, and death often ensues.

The author has invariably found bacteriæ and streptococci in the different organs, but was not able to find the micro-organisms *in vivo*. The disease is of great interest, because it often begins with a phlegmonous angina as in the cases of Senator and others. Some cases are treated with salicylic acid with good results. **Michael.**

Meeting, April 10, 1888.

LEYDEN exhibited his tubes for treatment of strictures of the œsophagus (see Report, *Journal of Laryngology*, 1888, No. 1). **Michael.**

Congress of Physicians in Hamburg.

Meeting, April 17, 1888.

THOST exhibited two patients with stenosis of the larynx (following typhus resp. syphilis) treated with Schrotter's tin-bougies, with good results. **Michael.**

Congress of Physicians in Munich.

Meeting, March 7, 1888.

ZIEMSSEN.—*Case of Papilloma of the Larynx.*

THE patient, fifty-seven years old, became hoarse in 1883. During latter years he was often operated upon by Professor Oertel, who removed small portions of papillomata, but invariably after some weeks there was recurrence, and the operation had to be repeated. In October, 1887, he became so dyspnœic that tracheotomy was necessary. The laryngoscope showed numerous papillomatous growths on both ligaments. The operation was very difficult, because of the dilatation of all the blood-vessels. Some minutes after the operation the patient died suddenly. Death was caused by fatty degeneration of the heart, which could not support the loss of blood and the narcosis. The autopsy was of great interest. There was a growth which presented the appearance of a non-ulcerated carcinoma, but the microscopical examination showed that it was a papilloma with "cell nests" on the surface.

BOLLINGER, who had made the examination of the specimen, remarked that the whole surface of the larynx was covered with growths of irregular contour, especially on the right side. The greenish growths were very hard, and if pressed exuded a milky fluid. The vocal ligaments were destroyed by the neoplasms, and the ventricles of Morgagni were filled with neoplasms. The microscopical examination showed that it was an epithelial tumour of papillomatous character, which showed only in small portions symptoms of malignancy. The tumour consisted of warty excrescences with a stroma of connective tissue and pavement epithelium. In some places were signs that the benign tumour would change into a papillary epithelioma (destructive papilloma). The lymphatic glands were not infected. The case is also of interest because it could be examined at so early a stage. It is certain that if the patient had survived the operation destruction of the laryngeal organs would have ensued. Malignant transformation of benign neoplasms can be caused by mechanical irritation, or arise from general debilitating influences. Total extirpation of the diseased part would have effected a cure. Microscopical examination of excised portions of growths often gives only uncertain results. Concerning the so-called "cancer nests," the author agrees with Virchow that they are also to be found in benign papillomata, but only in rare cases. In 14,000 autopsies, the author has found laryngeal cancroids in six cases primary, and in fifteen cases secondary. **Michael.**

Paris Surgical Society.

Meeting, March 28, 1888.

Maxillary Fistula.

M. QUENU showed a patient whom he had cured of a fistula consecutive to the opening of a dropsy of the maxillary sinus. Instead of following the classical practice, and recommending the wearing of a prothetic apparatus, he closed the fistula in the following way:—First, by a palato-gingival flap, turned so as to present exteriorly its raw surface; then to fix this flap, he detached a labial flap, which was applied to the first, the two raw surfaces being in contact with one another; and he attached this labial flap to two neighbouring teeth, and thus avoided any kind of suture.

M. BERGER: Was this not an orifice communicating with the bottom of a Magitot's cyst instead of a fistula of the maxillary sinus?

M. QUENU: It was a dropsy of the sinus caused by the existence of a stump. This is so true that when I opened the sinus in the first operation the patient experienced a passage of air in the sinus which gave him neuralgia.

M. BERGER: M. Magitot, had he been here, would have affirmed that the pretended lesions of the sinus coincident with stumps are nothing else than the cysts he has described. Indeed, dropsy of the sinus unaccompanied by suppuration is so rare that it is almost unknown; I have never met with it. However that may be, when the cavity of the sinus is open, the difficulty is not generally to shut this artificial orifice, but to keep it open, as it is necessary to do when there is suppuration of the sinus. M. Quenu's attempt seems to me useless, for the obliteration would have taken place in any case.

M. QUENU: The operation which had opened the sinus was an old one, and I did not see this orifice shrink; besides, the spontaneous closing of these fistulæ is not so general as M. Berger thinks. Why do classic books advise prothetic apparatus?

M. BERGER: Just so. They introduce this apparatus to close the fistula if necessary, but principally to hold it open at will.

M. QUENU: The opening of the fistula was larger in the case of my patient, but, above all, it was formed only of osseous walls simply covered with mucosa; spontaneous closure would have been impossible.

M. FERRIER: Evidently one must distinguish between the cases of dropsy of the sinus of which M. Quenu speaks, and cases of suppuration of this cavity on which M. Berger founds his argument; in the latter cases the tendency of the orifice is to close spontaneously. I cannot well explain the current of air passing through the sinus of which M. Quenu spoke. The nasal orifice of the maxillary sinus was certainly closed before the operation, since there was retention in the sinus; how then could it have been open afterwards to let this current of air pass?

M. QUENU: When I opened the cyst, blood flowed through my patient's nostril, which proved that communication then existed between the sinus and the nasal fossæ, or had just been established.

M. BERGER: The reality of simple dropsy of the sinus does not seem to me to be completely established by this fact,—above all, if one remembers that the error is a very natural one when one only possesses the indications given by the details of an operation. I have shown with M. Magitot a specimen representing a dentary cyst having completely invaded the sinus in such a manner that the cavity of the cyst simulated the interior of the sinus. The error had been committed. I think it might be repeated, and that one might mistake for dropsy of the sinus a cyst simply in the vicinity.

M. FERRIER: I am inclined to accept this explanation after what M. Quenu has just said. In his first operation he must have opened a dentary cyst and burst the wall of this in the interior of the sinus. The blood thus passed into the sinus, then into the nasal fossæ by the natural orifice of this cavity.

M. QUENU: That might be; but I did not intend in my communication to open the question of pathogeny—I only intended to show the result of an operation which happily resulted in closure of an otherwise incurable fistula.

M. BERGER: The question of the pathogeny is the most important, for it is well known that cysts of the jaws, once open, heal without a complementary operation. **Joal.**

French Society of Otology and Laryngology.

Meeting, April 26, 1888.

President: M. BOUCHERON. Vice Presidents: M. MOURE and M. SCHIFFERS. Secretary: M. JOAL.

M. MOURE.—On *Ozæna.*

HE understands by ozæna, a non-ulcerative affection, with crust concretions, and eliminates bad odours which are not ozænic. He reviewed the different theories regarding ozæna. Zaufal finds the etiology in arrested development of the turbinated bodies, from which arises excessive space in the nasal fossæ, an insufficient cleansing of the expired air, and decomposition resulting of secretions. This opinion is shared by Morell Mackenzie. Fraenkel attributes ozæna to inflammation of the pituitary mucosa, leading to hypertrophy, followed by atrophy, with chronic catarrh and decomposition of the secretions.

MICHEL, of Cologne, believes in an affection of the sinus.

ROUGE sees the cause in an affection of the bones.

ZIEM regards it as due to a ferment of microbic nature.

LOEWENBERG believes in a special micrococcus.

Others have found atrophy of the mucosa and turbinated bodies, with arrest of nutrition of the bones, and sclerotic rhinitis. The glandular tissue disappears, leading in turn to disappearance of the ozæna.

MOURE attributes ozæna to inflammation of the glands of the nasal fossæ and accessory cavities, to catarrh and prolonged sojourn of secretions, and the presence of a micro-organism. If Zaufal's view were true, cure would be impossible; if Fraenkel's, then amelioration could be obtained.

Treatment is varied, and though local treatment is essential, general medication should not be neglected. Local treatment may be douches, or sprays; aspirations, and retropharyngeal gargles are less active. The wool tampons of Guérin are troublesome. Antiseptic powders and liquids are of the first importance, *e.g.*, phenic acid, boric acid, chloral, salicylic acid, resorcin; then astringents, *e.g.*, tannin and alum. Alkaline solutions cause the odour to disappear, *e.g.*, bichromate of soda, borax, Sales water, sulphur water, chlorate of potash. Permanganate of potash ought not to be employed, because it stains the linen. Treatment should be continued two or three times daily for some years. In young girls the advent of menstruation often leads to recrudescence of the condition. If more active measures are required, these are, touching the mucous membrane with nitrate of silver, the galvano-cautery, scarification or removal of the turbinated bodies. General tonic medication, cod-liver oil, iodide of potash, a season at Sales-les-Bains, is an indispensable adjuvant.

M. CHATELLIER regards ozæna as a sclerotic rhinitis. He had examined the nasal mucous membrane, removed at the autopsy of a man who had ozæna, and who died of pericarditis. On opening the sphenoidal and ethmoidal cells, and

the antrum of Highmore, an abundant pus escaped without any odour. The glands had completely disappeared from the middle part of the inferior turbinated bodies.

He asked, if ozæna was cured as age advanced, was there not a regeneration of the glands? He had seen the mucous membrane in such patients equal the thickness of the normal membrane. Was it atrophied?

M. NOQUET admits regeneration of the mucosa. The enlargement alone is insufficient to explain the odour.

M. COUPARD believed the glands were regenerated. He employs iodoform or salol gazue, placed in the nasal fossæ, which is borne very well.

M. RUAULT reminded the meeting that Prof. Cornil had found the microbe of Loewenberg, and had cultivated it on gelatine, and reproduced the odour of ozœna, which was due to a ptomaine. Luc had also found a microbe stained by aniline in tracheal ozæna, and which was identical with Loewenberg's microbe. There are many microbes, and each gives a different odour.

Ruault does not believe in regeneration or cure. Antiseptic treatment is the best, and tampons of terebinthine are useful. He employs naphthol (naphthol, 12 grammes; alcohol [90°], 84 grammes).

A teaspoonful of this mixture is added to a litre of water for each injection, each teaspoonful representing 50 centigrammes of naphthol.

M. GOUGENHEIM thinks with Ruault that there is not only one microbe but probably several, not only one cause of fœtidity but many. They have not all been discovered yet. The odour of the different kinds of rhinitis is also different, probably varying according to the kind of microbe. Atrophic rhinitis is then not the only cause of fœtidity; it may exist in hypertrophic rhinitis, and sometimes the same patient may have simultaneously atrophic rhinitis on the one side, and hypertrophic on the other. As to the dilatation of the nasal fossæ, even when not an accompaniment of atrophic rhinitis, and when consecutive to nasal polypi, M. Gougenheim has always seen it accompanied by a fœtidity much less accentuated than in ozæna, and apparently caused by the presence and fermentation of crusts. As for the treatment of ozæna, Gougenheim is eclectic, and thinks that success is fairly certain, provided that the action of the medicament is not too rapid.

M. CHARAZAC (Toulouse) mentions cases of patients having crusts and enlargements, and hypersecretions without the least odour.

M. BARATOUX insisted on the difference between fœtid and atrophic rhinitis. There is only one difference in the microbes. It is always the diplococcus of Loewenberg which produces ozæna.

M. MOURE had never seen a patient with enlarged cavities minus odour.

M. RUAULT terminated the discussion by pointing out that ozæna must not be confounded with other more or less fœtid odours.

M. CHARAZAC read a paper called *Observations on Cancer of the Larynx. Considerations of Laryngectomy.*

PATIENT, sixty years old, in consequence of the abuse of the voice and of tobacco, had frequent hoarseness, followed by aphonia. He soon lost his voice completely, and darting pains were felt on a level with the larynx, more intense at night. General health good, and patient breathed freely. Laryngoscopic examination showed the right vocal cord ulcerated and tumefied, and on the same side the summit of the arytenoid and the aryteno-epiglottic fold were congested. On the left side there was also a little redness of the vocal cord. Same on epiglottis. Gibert's syrup and cod-liver oil were given. Two months after examination intense respiratory trouble and suffocative crisis existed. At laryngoscopical examination the tumour formed a bright red projection. The patient had sanguineous

expectoration. After two months radical cure was attempted, the trachea opened, and the tumour excised. Quick recurrence ; the tumour reappeared, raising the epiglottis, but without glandular trouble.

The author quotes this observation to draw conclusions as to the wisdom of interference in malignant tumours of the larynx. According to Baratoux' statistics, out of 135 extirpations of the larynx for malignant tumours, two-thirds of the patients died. Partial ablation of the larynx is more serious than lateral or total. According to Schwarz, tracheotomy may prolong life for a year or more.

Solis-Cohen is averse to laryngotomy. Before interfering, the indications must be taken into account. Extirpation must not be attempted after seventy, or, if the patient is feeble or dyspnœic. In these cases tracheotomy should be performed instead. In all these cases, especially if there is glandular inflammation, recurrence always takes place.

According to Butlin, cancer extrinsic in the larynx is the worst ; intrinsic cancer is the next best from the point of view of recurrence, and partial ablation may be more favourable still.

The diagnosis from syphilitic conditions is sometimes very difficult. It is unwise to interfere before having tried an energetic anti-syphilitic treatment. And when once ablation *has* been decided upon, it should be performed at an early stage of the disease.

M. RUAULT is not surprised that death should so frequently result from the operation ; people always operate too late ; the surgeon who sees the tumour is not a laryngologist, and very often the laryngologist is not a surgeon. The patient generally dies of cachexia, and specific diagnosis is often most difficult.

M. MOURE, in support of Butlin's opinion, said, in one case, an epithelioma extending over the pharynx and larynx recurred after extirpation, under the tongue and in the sub-maxillary glands. In a second case the cancer was an intra-laryngeal one ; ablation was successfully performed. Moure mentioned those palliative operations which most frequently are only intended to ward off immediate death or to prolong life a little. Amongst these operations he named opening of the larynx and scarification.

M. MOURE agreed entirely with Charazac in thinking operations on very old people useless ; he has found aortic insufficiency develop in consequence of the shock produced by tracheotomy. In another case of thyrotomy, Trendelenburg's canula having been left in to arrest hæmorrhage, the patient was asphyxiated ; the canula was removed, and the patient recovered ; they replaced it, and the same series of accidents ensued. This occurred several times, and could only be attributed to compression of the pneumogastrics.

M. COUPARD mentioned a patient who was believed by French and German specialists to be suffering from cancer of the larynx, but was, nevertheless, subjected to anti-syphilitic treatment and then tracheotomized. He was finally cured by injection of mercuric peptonate.

M. BARATOUX instanced certain statistics spoilt by the same observations being employed three or four times, under a different form, from which ensue a number of supposed successes. He gave some statistics of extirpation, total, partial and lateral, and drew a parallel between these operations and tracheotomy. He mentioned cases which had survived the operation two, seven, and nine years respectively.

M. GOUGENHEIM asked if histo'ogical examination had been conscientiously made, and if tubercular or syphilitic vegetations had not been taken for cancer ?

M. BARATOUX replied that in these cases of survival the microscopic examination had been made.

Sitting, April 27.

M. MIOT made *Remarks upon Certain Nasal Obstructions dependent on thickening of the Quadrangular Cartilage of the Septum.*

HE insisted on the use of the chemical galvano-cautery, and on galvano puncture as treatment for this condition. He has constructed some new galvano-caustic instruments for the purpose. The first end is attained with a current of fifteen milliampères strength; even this leads to pain, lachrymation, and much congestion. Twenty-five milliampères will produce syncope. Galvano-puncture is preferable on account of rapidity of action.

Sitting, April 28.

M. JOAL read a paper on *The Headache of Infancy.*

THIS headache is characterized by persistence, inaptitude for work, sadness, vertigo, &c. He enumerated the different theories advanced to account for the condition. Oculists accuse the eyes (errors of refraction), rhinologists the nose. He quoted two cases, one a young man in whom treating the inferior turbinated bodies cured the cephalalgia, and the other case occurred in a young girl, in whom at each menstrual period there was recrudescence of the headache. He concluded (1) that local treatment ameliorates and cures the cephalalgia; (2) That irritative genital influence is evident, since recurrences have coincided with (in the first case) herpes preputialis, and (in the second) with menstruation. He concludes with J. N. Mackenzie that there is a connection between the nose and the genital apparatus, and has before, in a memoir upon epistaxis, called attention to parallel between menstrual congestion and erection of the pituitary body.

M. NOQUET thought the erection of the nasal mucosa was not the sole origin of the headache. There was also median otitis.

In answer to a question of M. Moure, M. Joal replied that the headache was prefrontal, and one could make it appear by pressing on the orbital nerve. Posterior cephalalgia seemed rather to be in relation with the pharynx or naso-pharynx.

M. MOURE had seen coryzas accompanied with retention of inflammatory products in the frontal sinus give rise to intense suborbital cephalalgia.

M. BOUCHERON believed the condition to be much more complex, and besides a diathetic condition there were local manifestations.

M. SCHIFFERS remarked that in cephalalgias of nasal origin, the seat of pain is constant, viz., at the root of the nose, and at the level of the frontal sinus recalling gastric headache. The auricular cephalalgias mentioned by M. Noquet are always lateral and temporal.

M. HERYNG called attention to disorders of the sphenoidal sinus, which are only indicated by headache, sometimes accompanied with catarrh or hypertrophy of the mucosa and rhinitis. It is best to explore with a probe; pus, blood, and osseous *débris* will come away.

M. NOQUET was to have read a communication on *A Fibroma of the Left Inferior Turbinated Body.* But having his doubts as to the real nature of the tumour, he would relate an observation on chronic abscess developed in the root of the tonsil. The patient, twenty years old, was operated upon, when six years old, for hypertrophy of the tonsils, and for six months had suffered from considerable pain in deglutition. On examining the stump of the left side, and pressing from top to bottom, pus exuded. A more complete examination showed the existence of a small cavity. After anæsthesia with cocaine an incision was made parallel with the pillar. Improvement was marked; but there was recurrence, and the galvano-cautery was used on the "stump," with the result that the abscess was cured. The pus was not reserved, so that research for bacilli could not be made.

M. HERYNG had seen two analogous cases; but the diagnosis was made at the moment of ablation. The tonsil being adherent to the pillar, the decomposed pus was situated in a cavity the size of a nut, with smooth walls.

M. MOURE asked if, in amygdalotomy, hæmorrhage was not to be feared?

M. NOQUET pointed out a case of terrible hæmorrhage in a child six years old the day after the operation.

M. HERYNG quoted Solis-Cohen who, out of 11,000 amygdalotomies, only had four deaths. Schmidt and Michel do not employ amygdalotomy; but with a galvano-caustic loop they have never had a failure. As to M. Heryng, having tried this in the case of a student, the next day there was hæmorrhage that threatened to be fatal. Examination of the tonsil showed vessels of enormous size and in considerable quantity. Gargles are inconvenient. Ice must be placed in the mouth.

M. MÉNIÈRE, in 500 ablations of tonsils with the tonsillotome, has never had an accident. He tampons the "stump" with pure lemon juice or with essence of turpentine.

M. GELLÉ, having also had an accident, has since employed St. Germain's method. The tonsils are scarified with the thermo-cautery in two or three sittings, and the volume is diminished without producing inflammation.

M. CHARAZAC employed this method for adults. It is not very painful.

M. NOQUET did the same, and has never seen consecutive hæmorrhages produced with the cautery.

M. MOURE has seen, in children, after the use of the thermo-cautery, retro-pharyngeal and peritonsillar abscesses.

M. SCHIFFERS thinks that the swallowing of blood plays a great part in the production of hæmorrhages. The efforts at vomiting cause the eschars to fall, from which hæmorrhage supervenes.

M. MÉNIÈRE, of Paris, read an observation on a case of quotodian headache, lasting two years, and cured by nasal cauterization and ablation of the adenoid masses. The patient showed all the symptoms of adenoid tumours of the posterior pharynx. The cephalalgia was cured by cautery points applied to the hypertrophied inferior turbinated body.

REVIEWS.

Transactions of the Academy of Medicine in Ireland. *Vol. v.* 1887.

IN this important volume, which contains a large amount of most interesting material, we notice several papers which have a direct interest to readers of this Journal. DR. C. J. NIXON records a *Case of Myxœdema*, occurring in a woman of forty. The author states that the relation between thyroid atrophy and cretinism has not been clearly established, but much more determinate is the relation of myxœdema to atrophy or ablation of the thyroid gland, as has been experimentally proved. The author discusses the function of this gland, and thinks "it may be regarded as one of those rudimental organs which, by removing certain elements from the blood, fit this fluid for the nutrition of other parts, and in this way effect a balance in the processes of nutrition." A paper by DR. MOUILLOT *On an Outbreak of Diphtheria* has already been quoted at length in this Journal (*vide* vol. I., p. 154). DR. M. A. BOYD contributes an interesting article entitled *Some Notes on the Mineral Springs of Auvergne*, in which he refers to Royat, La Bourboule, Mont Dore, and Chatel Guyon. The author speaks of the beneficial results obtained at La Bourboule and Mont Dore in throat, laryngeal, and naso-

pharyngeal troubles by inhalation and spraying of the waters, and of the latter waters, when inhaled for ulcerating tubercular cavities in the lungs, but thinks the air and high altitude have more to do with their beneficial effects than the waters themselves. (? Is not this the case with most watering places.) DR. J. K. BARTON contributes a paper on *Œsophagotomy to Remove a Foreign Body*, an operation which is now accepted by surgeons as a safe and justifiable proceeding. Experience proves that it is not easy to remove a foreign body through the mouth with *safety*. They are thus allowed to remain in the gullet a long time before operation is decided upon—operation should be resorted to as soon as a fair trial has been made of other and milder measures and proved unsuccessful, and œsophagotomy should not be delayed. After-treatment is always difficult and feeding will always be a trouble. The author thinks that in most cases feeding by a tube, not through the mouth but *through the wound*, is the safest and best method. This, of course, presupposes that failure results to obtain primary union, and in these cases a catheter or rubber tube should be introduced, and thrice a day injections of suitable food be made into the stomach. Mr. Barton then details a case in which he performed œsophagotomy on a young child (age not stated), who had swallowed a steel roller three months previously, and which was impacted on a level with the hyoid bone. After the operation the child suffered from a series of epileptic fits, tearing the antiseptic dressings from the wound, and ejecting the contents of the stomach through it. The fits were controlled by bromides, and feeding was accomplished by the tube introduced through the wound. The child made a good recovery, notwithstanding great emaciation and bedsores. Mr. HENRY GRAY CROLY contributes a case of *Sarcoma of the Tonsil*, fully reported in this Journal, Vol. I., p. 270. Mr. EDGAR FLINN gives notes of a case of *Stricture of the Œsophagus*, of which he exhibited the post-mortem specimen. (See this Journal, Vol. I., p. 118.)

A most interesting paper is contributed *On the Prevalence and Distribution of Phthisis and other Diseases of the Respiratory Organs in Ireland*, by Dr. T. W. GRIMSHAW, Registrar-General for Ireland. Phthisis is the most destructive disease in Ireland ; bronchitis comes next. The mere presence of towns will not account for this, as is shown by the maps accompanying the paper. It is also found that where most mountains are found, the lowest death-rate from phthisis prevails. Where the rainfall is greatest, phthisis prevails least ; but this may only be a coincidence. The more equable temperatures are less favourable to the development of phthisis. Other pulmonary complaints prevail most in districts where phthisis is least. The paper, which is a most important contribution to the subject, is illustrated with copious statistical tables and coloured maps.

Many other most important surgical and medical papers are contained in these Transactions.

Annual of the Universal Medical Sciences.—*A Yearly Report of the Progress of the General Sanitary Sciences throughout the World. Edited by Charles E. Sajous, M.D., and seventy Associate Editors, assisted by over two hundred Corresponding Editors, Collaborators, and Correspondents: Illustrated with Chromo Lithographs, Engravings, and Maps. Published by F. A. Davis, Philadelphia and London.* 1888.

THIS is a magnificent work, and one worthy of our American brethren. It contains a summary of the year's work in every branch, department, and specialty of

medicine, surgery, and therapeutics; each department being edited under the supervision of a competent authority. The five volumes really form a most complete system of medicine and surgery, and have less the character of a collection of simple abstracts than of a compilation of original articles. Some of the sections, indeed, read more like essays on given subjects.

Diseases of the nose and accesory cavities are edited by Dr. C. E. Sajous. Considerable space is given in this section to an abstract of Schwabach's researches on the pharyngeal bursa, which is illustrated by excellent plates, produced from the "Archiv für Micros-Anatomie." The whole of this section is well reviewed by the editor. Diseases of the pharynx are under the editorship of Dr. Bryson Delavan. Dr. J. Solis-Cohen reviews the literature of the larynx, trachea, and œsophagus. Although we miss much work that might well have been included in this section, the editor has, on the whole, made a judicious selection. A full account is given in this section of the recent lecture by Virchow on "Pachydermia laryngis." Diseases of the thyroid gland are cared for by Dr. John Guitéras, and a good account is given of the ever-increasing literature on this subject. In the section on diseases of the lungs, a good deal of space is given to the Bergeon treatment by gaseous injections. One of the most able and interesting sections of the work is the review upon general therapeutics by Dr. W. Pepper and Crozier Griffith. The five large volumes which compose this great work should be in the library of every practitioner, whether physician, surgeon, or specialist, who desires to keep pace with the advancement of the healing art. The many coloured plates which adorn the various sections of the work are carefully executed. The printing of the book is good, and both editors and publishers are to be complimented upon the fulfilment of a stupendous task in a highly satisfactory manner. We only hope that the venture will meet with the support that it merits.

GEORGE STOKER.—Deviations of the Nasal Septum. J. and H. Churchill, 1888.

THIS essay of thirty-four pages is a reprint of a lecture delivered by the author, and is a fair summary of the subject. He, however, only casually mentions enchondroses. Many of the so-called exostoses are really nothing more than cartilaginous excrescences. The author deals fully with the treatment of these conditions, and we quite agree with him in the statement that the use of chisels, mallets, and gouges, is too forcible a method to be desirable.

NOTES.

The **American Laryngological Association** will hold its Tenth Annual Congress in Washington, D.C., on September 18, 19, and 20, 1888. The following papers are promised:—

1. "Ten Years of Laryngology," by Rufus P. Lincoln, M.D., of New York.
2. "Congenital Bony Occlusion of the Posterior Nares," by Chas. H. Knight, M.D., of New York.
3. "The Effects of Varying Rates of Stimulation on the Action of the Recurrent Laryngeal Nerve," by Franklin H. Hooper, M.D., of Boston.

4. "Subglottic Laryngeal Enchondroma," by E. Fletcher Ingals, M.D., of Chicago.
5. "A Photographic Study of the Laryngeal Image during the Formation of the Registers and Production of Variations in the Pitch of the Singing Voice,' by Thomas R. French, M.D., of Brooklyn.
6. Lupus of the Nose, Pharynx, and Larynx," by Samuel Johnston, M.D., of Baltimore.
7. "Imaginary Lingual Ulceration," by Geo. M. Lefferts, M.D., of New York.
8. "A Possible Substitute for Tracheotomy and Intubation in Certain Cases," by Edgar Holden, M.D., of Newark.
9. "Antiseptic Nasal Surgery," by Clarence C. Rice, M.D., of New York.
10. "A Case of Sarcoma of the Tonsil," by Alex. W. MacCoy, M.D., of Philadelphia.
11. "A Case of Subglottic Chronic Stenosis of the Larynx, cured by Dilatation," by Frank Donaldson, M.D., of Baltimore.
12. "Internal Œsophagotomy," by John O. Roe, M.D., of Rochester.
13. "The Treatment of Atrophic Rhinitis by the Galvanic Current," by J. H. Hartmann, M.D., of Baltimore.
14. "The Anatomy of the Nasal Chambers," by Harrison Allen, M.D., of Philadelphia.
15. "Notes on a Case of Nasal Caries, complicated with Meningitis; successfully treated by means of a Surgical Drill," by Wm. C. Jarvis, M.D., of New York.
16. "The Fixation of one or both Vocal Bands in the Phonatory Position (so-called Abductor Paralysis)," by F. Donaldson, jun., M.D., of Baltimore.
17. "Residence at Certain High Altitudes as a Means of Cure for Laryngeal Phthisis," by Clinton Wagner, M.D., of New York.
18. "Further Investigations as to the Existence of a Cortical Motor Centre for the Human Larynx," by D. Bryson Delavan, M.D., of New York.

Papers have also been promised by Drs. Morris J. Asch, J. Solis-Cohen, John N. Mackenzie, Beverley Robinson, and A. Gougenheim (of Paris).

British Laryngological and Rhinological Association.—On Friday evening, June 29, the balloting papers which had been forwarded to each original member of this Association were opened, and, on the votes being counted, it was found that the following gentlemen had been elected as first officers of the new Society:—

President—Sir MORELL MACKENZIE.

Vice-Presidents—

1. England—Mr. LENNOX BROWNE.
2. Scotland—Dr. G. HUNTER MACKENZIE.
3. Ireland—Dr. PHILIP SMYLY.

Members of Council—

1. Metropolitan—Dr. WHIPHAM, Dr. WOAKES.
2. Extra-Metropolitan—Mr. BABER, Mr. MCINTYRE.

Secretaries—

1. Metropolitan—Mr. GEORGE STOKER.
2. Extra-Metropolitan—Dr. R. A. HAYES.

The Society is now fully constituted.

London: Pardon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Articles, p. 287.—Dr. Hunter Mackenzie : Malignant Disease of the Upper Air-Passages. Dr. Norris Wolfenden : On Angiomata of the Larynx.

New Instruments and Therapeutics, p. 294.—Hovell and Wright : New Post-Nasal Forceps. Cousins : New Gag. Eulenberg : Electrode. Gooding, Fox, Lennox Browne, and Whistler : Cocaine. Taylor : Antipyrin. Hedley : Saccharin. Stevenson : Carbolic Acid in Nasal Catarrh. Greene and Drzewiecki : Pertussis. Keetley : California for Consumptives. Allan : New Zealand for Consumptives. Murrell : Syrup of Tar in Winter Cough. Fraser : Antisepsis in Phthisis. Stephens : Tracheal Cough Harnach : Aqua Calcis.

Diphtheria, p. 296.—Jacobi : Therapeutics of Diphtheria. O'Donnell : Diphtheria in Pregnancy. Fernald : Three Unusual Cases. Beaver : Peroxide of Hydrogen in Diphtheria. Casadesús : Pilocarpine in Diphtheria. Guelpa : Nutriment in Diphtheria. Raven : Treatment of Diphtheria, etc.

Mouth, Tonsils, etc., p. 301.—Harkin : Suppression of Salivary Secretion. Carleton : Syphilis communicated through the Saliva. Jouillard : Cancer of the Sub-maxillary Gland. Thomson : Scald of the Tongue. Dickinson : The Tongue as an Indication of Disease. Loveridge : Herpetiform Eruption in Tonsillitis. Ruault : Reflex Neuropathic Phenomena. Corominas : Hypertrophied Tonsils Cured by Scarlatina. Angina. Wright : Galvano-Cautery in Enlarged Tonsils : Von Hoffmann : Treatment, etc., of Angina Tonsillaris. Felici : Granuloma or Sarcoma of the Pharynx.

Nose, Naso-Pharynx, etc., p. 304.—Walsham : Method of Applying the Nasal Truss. Country Practitioner : Rosaceous Nose. Sandford : Persistent Sneezing. Ziem : Facial Erysipelas. Cozzolino and Massini : Rhinoliths. Platt and d'Antona : Fibro-Sarcoma of Naso-Pharynx. Heydenreich : New Method of Removing Naso-Pharyngeal Polypi.

Larynx, p. 306.—Mackenzie : Chronic Laryngitis and Tracheotomy. Loewe : The Removal of Secretions from the Larynx. Steell : Spontaneous Detachment of Laryngeal Polypus. Audubert : Cyst of Larynx. Kidd : Angioma. Urunuela : Fibrous Polypus of Larynx. Sota and Waldo : Intubation. Wolfenden and Jurist : Perichondritis. Fussell : Fracture of the Larynx. Arbolella : Aphasia after Typhoid Fever. Joubert : Thyrotomy for Foreign Bodies. Luc and le Dentu : Chloroform in Tracheotomy. MacCormac, Jessett : Immediate Closure of Tracheal Wounds. Jones : Tracheotomy.

Neck, p. 310.—Hovell : Treatment of Goître. Thornton : Ibid. Ormsby : Congenital Goître. Cran : Enormous Goître. Page : Torticollis. Tresilian and Laycock : Myxœdema.

Societies, p. 312.—Academy of Medicine Ireland ; British Medical Association —Branches ; Pathological, Clinical, Medical.

Review, p. 316.—Wolfenden and Martin : Pathological Anatomy.

New Preparations, p. 317

Notes, p. 318.—British Medical Association ; Dr. Hunter Mackenzie.

The Throat & Voice.

Chlorate of Potash Tabloids.

FOR AFFECTIONS OF THE VOICE, THROAT, AND RESPIRATORY SURFACES GENERALLY.

By using these Tabloids the drug is effectually brought in contact with the oral mucous surfaces as a continuous gargle, and its specific action made certain. In acute sore throat, Chlorate of Potash "usually relieves the uneasiness in a few hours" (Cohen). "It is used in ulcerated mouth and follicular pharyngitis, and has been employed in croup, diphtheria, and spasm of the larynx" (Brunton).



Retail price, 6d.

"Of convenient size, they are beautifully made; and, as they dissolve slowly in the mouth, are well suited for throat affections."—The LANCET.

Supplied in beautifully graven white metal boxes, blue silk label, at 6d. and 1s. each.

Chloride of Ammonium Tabloids.

The solvent and discutient as well as antiphlogistic powers of Chloride of Ammonium are well known, and have led to its extensive employment, especially in Germany, in cases of sore throat and bronchitis, attended with abundant secretion of thick and tough mucous or phlegm. Physicians will at once appreciate the great advantage to their patients of the local effects of this salt slowly dissolving and coming in direct contact with the inflamed surface. It at once mitigates the cough or irritation, and lessens expectoration. Two or three of the Tabloids will sometimes entirely relieve coughs that have long resisted treatment with ordinary remedies. One may be dissolved occasionally on the middle of the tongue, not near the tip.

Supplied in bottles, at 6d. and 1s. 6d. each.

Sal Prunella Tabloids.

"A popular remedy, sometimes successful in mild cases of incipient inflammatory sore throat, is a small piece of nitre allowed to dissolve slowly in the mouth" (Waring). An excellent saline for throat cases, having very marked local efficacy when slowly dissolved on the tongue. It is a popular remedy, and for mild inflamed sore throat its ancient reputation is deserved.

Directions.—One or more (5 gr.) Tabloids should be dissolved slowly in the mouth for the local effect.

Supplied in bottles of 100, at 1s. 6d.

Tabloids of Compressed Chlorate of Potash with Borax.

The Tabloids afford an agreeable form in which to prescribe Chlorate of Potash and Borax.

Supplied in beautifully graven white metal boxes, pink silk label, at 6d. and 1s. each.

Voice Tabloids.

Voice Tabloids contain COCAINE, CHLORATE OF POTASH, AND BORAX.

The most agreeable form in which to prescribe Cocaine is in the Voice Tabloids with Chlorate of Potash and Borax. These Tabloids clear the voice and impart to it a silvery tone.

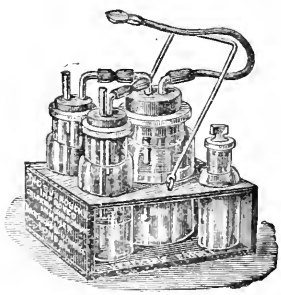


The Voice Tabloids supplied in beautifully graven white metal boxes, blue silk label, at 1s. and 2s. each.

Chloride of Ammonium Inhaler.

(VEREKER'S PATENT.)

"The vapour of Chloride of Ammonium removes unhealthy and offensive secretions, and restores the long diseased or weakened nasal and respiratory mucous membrane to a healthy state, so that in cases of catarrh, where thickening, induration and irritation exist, a most decided improvement is brought about in a short time." In "throat-cough," pharyngeal irritation, and relaxation and weakness of the throat, it acts as a most effective alterative and tonic to the mucous membrane.



The Burroughs Chloride of Ammonium Inhaler affords perfectly neutral fumes, and is always ready for use.

Dr. FRANKS, Dublin University, says:—"It is the best I have ever used, and I think I have tried all."

Dr. SMYLY, Ex-Pres. Royal College of Surgeons, Ireland, says:—"It is the best Inhaler for Chloride of Ammonium I have met with."

Price, 10s. each.

Supplied by all Chemists throughout the world.

BURROUGHS, WELLCOME & CO.,
Manufacturing Chemists,
SNOW HILL BUILDINGS, LONDON, E.C.

THE
JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. AUGUST, 1888. No. 8.

Contributors of original articles receive Fifty Reprints gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

MALIGNANT DISEASE OF THE UPPER AIR-PASSAGES.

By G. HUNTER MACKENZIE, M.D.

MALIGNANT disease may originate in any portion of the upper respiratory tract. It is a common affection of the larynx, is rare in the trachea, and moderately prevalent in the thyroid gland. Of 750 cases of malignant new growths, six were carcinomas of the larynx, four of the pharynx, and five of the thyroid gland.[1]

Within the larynx epithelioma (squamous-celled carcinoma) is most frequently met with. Sarcoma of the larynx is a rare disease. Sir Morell Mackenzie[2] has only met with five cases of it. Butlin[3] mentions twenty-three cases as having been collected by him. Cylindrical or columnar-celled carcinoma is extremely rare, and only one case is reported by Butlin.[4] Regarding other forms of malignant disease, it is probable, as pointed out by Lennox Browne,[5] that the variety known as medullary or encephaloid, is really a small-celled sarcoma, whilst the scirrhous is a spindle-celled or alveolar sarcoma.

It is an interesting fact that Morell Mackenzie[6] has never met with a case of secondary cancer of the larynx originating in infection, and, on the other hand, knows of only one case in which the original disease having been in the larynx,[7] cancer has developed secondarily in other parts of the body. A case has been recorded by Rollier[8] in which metastases in lungs, liver, and brain, followed sarcoma and suppurative perichon-

1 *Aertzlicher Bericht des k. k. allgemeinen Krankenhauses zu Wien*, 1884.
2 *Diseases of the Throat and Nose.* Vol. i., p. 350, 1880.
3 *Malignant Disease of the Larynx*, p. 6, 1883.
4 *Op. cit.*, p. 34.
5 *The Throat and its Diseases*, p. 431, 1887.
6 *Op. cit.*, p. 349.
7 *Op. cit.*, p. 336.
8 *Verhandlungen der laryngologischen Section der* 58 *Versammlung deutscher Naturforscher*, &c., 1885.

dritis of the larynx; and Hermann[1] mentions an example of lympho-sarcomatous metastases *to* the larynx and trachea. Lennox Browne[2] quotes several instances of metastases to the lumbar glands, kidneys, and liver; and believes that the pulmonary organs are more frequently affected than is usually supposed.

Of fifty cases of malignant disease of the larynx collected by Butlin,[3] three had metastatic deposits in the kidneys, liver, and lungs, besides affections of various glands in each instance. These cases were all examples of epithelioma.

Metastases to and from the larynx, especially the former, must, however, still be considered to be of rare occurrence.

Primary cancer may originate at any point within the larynx, but is rarely infra-glottic. Butlin[4] found, in fifty cases of laryngeal cancer, that five were infra-glottic. The poverty in lymphatics of this region, as compared with the aryepiglottic folds and the supra-glottic area, is generally supposed to be, and doubtless is, the cause of this rarity. Regarding the precise seat of origin, M. Mackenzie[5] found that, in 56 out of 100 cases, one of the ventricular bands was the part first affected. Schwartz[6] affirms that the epiglottis and the vocal cords are most frequently attacked. Butlin,[7] who follows Krishaber, and divides the disease into intrinsic and extrinsic, found that the intrinsic was much more common than the extrinsic, and that, in the intrinsic variety the vocal cords, in the extrinsic the epiglottis, were the parts most frequently attacked.

The tendency for malignant disease first to manifest itself on the *left* side has obtained occasional recognition from writers. The presence of the œsophagus, as asserted by Ariza,[8] can have no possible influence in the causation of this, unless in those cases in which the disease has extended from the gullet. M. Mackenzie's[9] statistics do not indicate a marked difference, the proportion of left to right-sided cancer being as 18 to 17. Lennox Browne[10] has found that cancer, and also even simple inflammation of the tonsil, is more frequently left-sided.

The causation of laryngeal cancer is equally obscure with that of cancer elsewhere, and its discussion does not fall within the scope of the present paper. It is usually a disease of adult life, but mention may be made of a case of sarcoma in a child of seven, believed to be congenital (Butlin)[11]; as also to a case of epithelioma, of two years' existence, in a child of three, with microscopical examination by Virchow.[12]

1 *Beitrage zur Kentniss der malignen Lymphdrusen Geschwulste.* Berne, 1885.
2 *Op. cit.*, p. 439.
3 *Op. cit.*, p. 50.
4 *Op. cit.*, p. 35, et seq.
5 *Op. cit.*, p. 338.
6 *Des Tumeurs du Larynx.* Paris, 1886.
7 *Op. cit.*, p. 35, et seq.
8 *Elementos diagnosticos del cancer laringos.* Madrid, 1884.
9 *Op. cit.*, p. 338.
10 *Op. cit.*, p. 440.
11 *Op. cit.*, p. 8.
12 *Virchow's Archiv.*, Bd. 43, S. 129, 1868, and *Butlin, Malignant Disease of the Larynx*, p. 32, 1883.

Ziemssen[1] records three cases under nine years of age, and three between ten and nineteen years.

Cases are from time to time recorded, showing an *apparent* malignant degeneration of previously benign growths. Recently, Bryson Delavan[2] has recorded a case in which malignant disease seemed to supervene on a catarrhal laryngitis, with pulmonary phthisis. Solis Cohen[3] mentions a case in which, after thyrotomy for a simple laryngeal papilloma, epitheliomatous disease developed in the cicatrix of the operation wound, whilst the interior of the larynx remained free. An example is recorded by Schnitzler[4] of a papilloma, which had been removed and the base burned with caustic, being followed by carcinomatous disease and perichondritis. He could recall, however, only three such instances in his extensive experience. Stoerk[5] believes that this malignant transformation is hastened by endo-laryngeal operations, especially by burning. Böhmer[6] narrates a most interesting case of this malignant degeneration. A small portion was removed from a growth in the larynx, and under the microscope was found to be a simple papilloma. The tumour was afterwards extirpated, and now it presented the typical microscopical characters of carcinoma. Schnitzler[7] further reports a case of what may be called double transformation, *i.e.*, an example of a benign papilloma, which changed, first into a carcinoma and then into a sarcoma. Such facts have necessarily an important bearing upon the value to be attached to the microscopical examination of portions of laryngeal neoplasms, removed for purposes of diagnosis.

The glandular affections in cancer of the larynx merit some notice. It has been already remarked that metastases to distant glands, *e.g.*, the lumbar, have been noted, but it is the cervical, laryngeal, and tracheal glands which are most commonly affected. Butlin[8] asserts that sarcomata do not affect the glands, for the reason that sarcomata, owing their origin to the proliferation of the cellular elements of the connective tissue, the solid structures swell and cause a diminution in calibre of the lymphatic vessels, which proceeds to their complete obliteration, and renders them incapable of transmitting the infective material of the tumour. Browne[9] controverts this view, for in three out of four cases under his notice glandular complications were present.

Glandular enlargement may be present, and may not be detected during life. Butlin[10] himself records a case with apparently only one enlarged gland during life, but on autopsy half-a-dozen, similarly affected, were found under the muscles. These glands, especially the tracheal, bronchial, and deep cervical, are deeply situated, and may undoubtedly

1 *Cyclopædia of Medicine*, vol. vii., p. 891.
2 *New York Medical Record*, May 2, 1885.
3 *Report of the Fifth Annual Meeting of the American Laryngological Association.* 1883.
4 *Bericht uber die* 21 *Section der Naturforscher-Versammlung.* Wiesbaden, 1887.
5 *Wiener Med. Wochen.*, Nos. 49 & 50, 1887.
6 *Inaug. Dissert.*, Wurzburg, 1887.
7 *Op. cit.*
8 *Malignant Disease of the Larynx*, p. 14.
9 *The Throat and its Diseases*, p. 440, 1887.
10 *Op. cit.*, p. 12.

enlarge to a fair extent without manifesting this by appreciable signs during life, unless by pressure symptoms. There appears to be no rule or law in this matter, for cases have been recorded in which even infraglottic malignant disease has perceptibly affected the glands (Butlin).[1] Certain of the glandular affections met with in this disease may not be permanent, for, according to Lublinski,[2] they may be due to simple swelling and not to infection. Disappearance or subsidence of glandular swellings, therefore, does not contra-indicate the existence of malignant disease.

These glandular complications, not directly but indirectly through the nerves, modify in an important degree the symptoms of the disease. Thus Binaud and Moure[3] state that respiratory troubles may arise independently of the laryngeal tumour, most probably from (deep) glandular pressure on the nerves. Partial or complete paralysis of a vocal cord and hoarseness, which are both early symptoms of the disease, doubtless arise in this way. It may not be out of place to repeat that the glands causing these symptoms may be detected with difficulty, or not at all. The vagus, or more frequently its recurrent branch, is the nerve generally affected. The paralysis is usually on the same side as the disease, though not always (Jones).[4]

Malignant disease of the larynx occasionally runs a very rapid course. Newman[5] records a case of alveolar sarcoma which terminated in about three months from its probable commencement. In sarcoma, however, the course is usually slow. The patient may die from cachexia or from dyspnœa (Hughes).[6] Birch[7] mentions a case of epithelioma of the epiglottis, where the patient died suddenly of suffocation. Death from hæmorrhage appears to be extremely rare. Butlin[8] records a case of severe and fatal bleeding after tracheotomy, and says there is only one death recorded as actually resulting from hæmorrhage, and in it the base of the tongue was affected.[9] Maydl[10] makes mention of a case in which, after extirpation of the larynx, death took place on the fourth day with vomiting of blood. (Gastric erosions present on autopsy.)

Perichondritis is not an unusual feature of malignant disease of the larynx. Sir M. Mackenzie[11] found necrosis of the cartilages in ten cases out of thirty-two (autopsies). Marigne[12] has demonstrated a preparation of "cancerous ulcerative perichondritis," along with cancerous degeneration of the left lobe of the thyroid, and West[13] has recorded a case of epithelioma with extensive and troublesome perichondritis. The latter

1 *Op. cit.*, p. 48.
2 *Berliner Klin. Wochen.*, Nos. 8, 9, 10. 1886.
3 *Journal de Méd. de Bordeaux*, *February* 27, 1887.
4 *Lancet*, August 2, 1884,
5 *Glasgow Medical Journal*, May, 1885.
6 *Philadelphia Medical and Surgical Reporter*, Sept. 13, 1884.
7 *Indian Medical Gazette*, May, 1887.
8 *Op. cit.*, p. 12.
9 *Op. cit.*, p. 42.
10 *Wien. Med. Presse*, No. 12, 1884.
11 *Diseases of the Throat and Nose*, vol. i., p. 340.
12 *Presse Médicale Belge*, No. 13, 1884.
13 *Transactions of the Pathological Society of London*, vol. xxxviii., p. 85.

case is instructive as illustrating that the perichondritis may be very intense, and the accompanying symptoms very slight. Other examples of perichondritis have already been incidentally mentioned in this paper.

Cancer of the larynx may co-exist with tubercular and syphilitic disease. Sokotowski[1] has recorded two cases of laryngeal cancer with pulmonary tuberculosis. Semon[2] has also witnessed this combination of cancer and tubercle. Bryson Delavan's[3] case of malignant disease with catarrhal laryngitis and pulmonary phthisis has been already referred to. The writer has met with an undoubted case of cancer accompanying tertiary syphilis of the larynx.

(*To be continued.*)

ON ANGIOMATA OF THE LARYNX.

By R. Norris Wolfenden, M.D. Cantab.

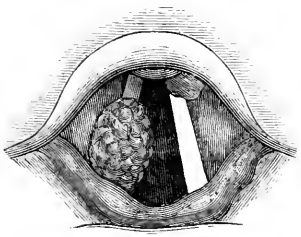
Angiomata are amongst the very rare tumours of the larynx. Only eleven cases are known to have been recorded, and the notes of the one published here by me for the first time makes the twelfth such case on record.

The patient, John N., a bootmaker by trade, aged forty-four years, came under my observation at the Throat Hospital, Golden Square, in 1887. He was then suffering from laryngeal catarrh ; but from having been an old attendant at the hospital, first under Sir (then Dr.) Morell Mackenzie, and afterwards under various medical men, he was fully aware of the curious laryngeal tumour he possessed. On several occasions the tumour appears to have been operated upon, and portions of it removed, both with the galvano-cautery and the forceps and guillotine. I could not learn if it had ever been radically extirpated, and had subsequently recurred, but it was evident that the second tumour on the opposite side had appeared at a long interval of time from the first. The patient described the condition as having been present for twenty years, and he had no doubt it must have been there for a long time before that. What first took him to the hospital appears to have been some hoarseness. When the patient gets a cold, he feels a slight sensation of a foreign body in the larynx, and occasionally becomes very hoarse. At the present time (when free from laryngitis) he is slightly hoarse, but possesses a fairly clear voice. This used to be quite clear, and it is only latterly that he has noticed much difference in it. Whereas he used to sing well in public, he finds it now impossible to do so. The advent of this hoarseness is probably coincident with the appearance of a second angiomatous growth about the left vocal cord. He complains of dryness of the throat, and says he cannot sleep well. He is a nervous, pale, and thin man. Occasionally he expectorates blood, but not in any great quantity. There is hæmorrhage from the nose at times when blowing it. The laryngoscope shows the

[1] *Gazeta Lekarska*, 17 & 18, 1886.
[2] *St. Thomas's Hospital Reports*, vol. xiii., p. 169.
[3] *New York Medical Record*, May 2, 1885.

presence of a large bright red tumour, situated upon the surface and edge of the right ventricular band, occupying its posterior two-thirds, and completely hiding the vocal cord except at its anterior third. The growth has the appearance of a small raspberry. The vocal cord moves freely under it, and is of normal appearance (such of it as can be seen). The second growth occurs at the anterior extremity of the left vocal cord, apparently slightly involving the end of the ventricular band also, is bright red, and very small. Breathing is never interfered with. Fearing considerable hæmorrhage if the parts were operated upon, I have not attempted any interference with the growth, especially as former operations have not apparently succeeded in removing the condition, and the patient experiences no great discomfort.

An illustration of the laryngeal condition is appended, taken from an excellent water-colour drawing of the larynx (executed by Mr. Procter S. Hutchinson, Resident Medical Officer to the Throat Hospital).



I append a complete list of such tumours already recorded :

Observer.	Patient.	Nature of Tumour.	Previous History.	Reference.
1. Fauvel.	Man, 53.	Cavernous angioma of right vocal cord. Pedunculated.	Dysphonia for a year.	*Traité des Maladies du Larynx*, 1876.
2. Fauvel.	Man, 37.	Cavernous angioma of edge of left vocal cord.	—	*Ibid.*
3. Mackenzie.	May, 1864. Man 64, (Physician).	Vascular tumour in right hyoid fossa.	Growth had given rise to uneasiness during previous 6 months. Dysphonia.	Essay on *Growths in the Larynx.*
4. Heinze.	Man, 38.	Cavernous angioma of right ventricular band, springing from the ventricle.	Chronic laryngitis and patient victim of phthisis.	*Archives of Laryngology*, 1880.

Observer.	Patient.	Nature of Tumour.	Previous History.	Reference.
5. Elsberg.	Man, 28.	Cavernous angioma attached along anterior third of right vocal cord.	Aphonia for 4 years.	*Archives of Medicine*, 1884.
6. Elsberg.	Man, 37.	Ibid. Pedunculated.	Naso-pharyngeal catarrh for several years.	*Ibid.*
7. Elsberg.	Woman, 52.	Cavernous angioma; right pyriform sinus.	—	*Ibid.*
8. Seiler.	—	Angioma right vocal cord.	—	Referred to in Schwarz, *Des Tumeurs du Larynx.*
9. Schwarz.	—	"Submucous capillary angioma."	No details given.	*Ibid.*
10. Kidd.	Woman, 50.	Cavernous angioma of anterior extremity of left vocal cord.	Aphonia for 8 or 9 years; bronchitis.	*Lancet*, 1888.
11. Desvernine.	Man, 53.	Pedunculated angioma of epiglottis.	Occasional bleeding from the throat; once severe hæmoptysis.	*Revista de Ciencias Medicas*, 1888.
12. Wolfenden.	Man, 44.	An angioma of right ventricular band and similar small tumour of anterior extremity of left vocal cord.	Has known it to be present for nearly 20 years; frequent attacks of laryngitis.	Unpublished.

I have not included in the list the vascular cysts observed by Johnson and others, or the vascular papillomata, of which several cases have been seen (Ariza, Hooper, &c.). These are not true angiomata.

Elsberg's essay on angioma contains all that can be said of these growths. They appear to accompany chronic catarrhs of the larynx, mostly occur in men, and give rise to the same symptoms as other

laryngeal neoplasms. Occasionally they lead to recurrent hæmorrhage, which may be mistaken for hæmoptysis.

The pathology of these growths will be illustrated in the "Studies in Pathological Anatomy" of myself and Dr. Sidney Martin.

NEW INSTRUMENTS AND THERAPEUTICS.

MARK HOVELL, T. (London).—**Forceps for Post-Nasal Growths.** *British Medical Journal, March* 3, 1888.

A MODIFICATION of Löwenberg's forceps. **Hunter Mackenzie.**

WRIGHT WILSON (Birmingham). — **Forceps for Post-Nasal Growths.** *British Medical Journal, March* 17, 1888.

A MODIFICATION of Löwenberg's forceps. **Hunter Mackenzie.**

COUSINS, WARD J. (Portsmouth).—**New Gag with Throat Guard.** *British Medical Journal, February* 18, 1888.

AN illustrated description of a gag, with which are combined a throat guard, a mouth mirror, and a tongue depressor. It is especially designed for the purposes of dental surgery, and for other minor operations on the mouth and gums. Makers, Messrs. S. Maw, Son, & Thompson, London. **Hunter Mackenzie.**

EULENBERG (Berlin).—**Modified Aural and Laryngeal Electrode.** *Monatsschr. für Ohrenheilk.* 1888, *No.* 5.

THE pole consisted of a little piece of cotton. By this arrangement the pain of the metallic electrode is avoided. **Michael.**

GOODING, C. E. (Barbadoes).—**Case of Cocaine Poisoning.** *Lancet, February* 25, 1888.

DELIRIUM and alarming collapse followed the injection into the gum of a young negress of half a grain of the salt. The author thinks that idiosyncrasy has a good deal to do with the induction of such symptoms in certain individuals. **Hunter Mackenzie.**

FOX, FORTESCUE (Strathpeffer).—**Alarming Symptoms produced by Spraying the Throat with Cocaine.** *British Medical Journal, February* 18, 1888.

RECORD of the case of a lady, in whom alarming symptoms of depression, with unconsciousness, developed after spraying the throat with a solution of cocaine. The strength of the solution is supposed to have been 2 per cent. **Hunter Mackenzie.**

BROWNE, LENNOX.—Cocaine in Tracheotomy. *British Medical Journal, April* 7, 1888.

AMONGST other advantages which cocaine possesses over chloroform is the comparative bloodlessness of the tissues which it induces. The author injects five minims of a 10 per cent. solution on each side of the immediate region at which the trachea is to be opened, and allows ten to twelve minutes to elapse before commencing the operation. In the great majority of cases no pain whatever has been experienced, and the resulting anæsthesia has been maintained sufficiently long to permit a careful performance of the operation. **Hunter Mackenzie.**

WHISTLER, W. M. (London).—**General Symptoms sometimes produced by Nasal Sprays of Cocaine.** *British Medical Journal, February* 4, 1888.

AFTER spraying with weak solutions, an increase in the rate and strength of the pulse, with a feeling of augmented vigour and capacity for mental effort, has been noted. In other instances, insomnia and active restlessness have resulted. After the application of strong solutions, vertigo and threatened syncope have been occasionally observed. The author believes, however, that it is only very exceptionally that limited applications of strong solutions in the nose produce general symptoms.

Hunter Mackenzie.

TAYLOR, COUPLAND H. (Teneriffe).—**Idiosyncrasy to Antipyrin.** *British Medical Journal, March* 31, 1888.

A LADY who had taken eight grains of antipyrin for migraine was seized with a severe attack of coryza, with great irritation of the larynx. The author recommends antifebrin in cases in which antipyrin disagrees.

Hunter Mackenzie.

HEDLEY, JOHN (Middlesborough).—**An Objection to the Use of Saccharin.** *British Medical Journal, February* 11, 1888.

AFTER administration for several days, saccharin produces a sweetening of the saliva and a feeling of nausea. [Subsequent correspondents suggest that the saccharin may either have been impure or may have been partaken of in too large quantities.] **Hunter Mackenzie.**

STEVENSON, NATHANIEL (London).—**Carbolic Acid in Nasal Catarrh.** *British Medical Journal, April* 7, 1888.

NOTE of a case apparently cured. **Hunter Mackenzie.**

GREENE, G. E. I. (Ferns).—**Carbolic Acid in Pertussis.** *British Medical Journal, April* 7, 1888.

A RECOMMENDATION of the internal administration of carbolic acid in this disease, with four (*sic*) illustrative cases. **Hunter Mackenzie.**

DRZEWIECKI, JOSEPH (Warsaw).—**Hydrocyanate of Mercury and Salol in the Treatment of Whooping Cough.** *Lancet, February* 25, 1888.

A RECOMMENDATORY note. **Hunter Mackenzie.**

KEETLEY, C. B. (London).—**California as a Residence for Consumptives.** *Lancet, February* 4, 1888.

A RECOMMENDATION of South California. Patients are recommended to avoid the coast, which is damp and foggy, and live high up in the mountains. **Hunter Mackenzie.**

ALLAN, LESLIE J. H.—Napier and Kuripapanga (New Zealand) as Health Resorts for Pulmonary Invalids. *British Medical Journal, February* 11, 1888.

THE author recommends the latter place as suitable for cases in which the lung is merely threatened, or when the disease has made but little progress. With such patients, residence there all the year would be desirable. Residences at Napier and Kuripapanga alternately will secure a fine climate all the year round. **Hunter Mackenzie.**

MURRELL, WILLIAM (London).—**Syrup of Tar in Winter Cough.** *British Medical Journal, March* 3, 1888.

THE author recommends the syrupus picis liquidæ (United States Ph.) in from two to four drachms every three hours, or oftener. Its efficacy may be increased by adding to each dose six minims of the 2 per cent. solution of apomorphine (B.P.). **Hunter Mackenzie.**

FRASER, WILLIAM (Ashburton).—**Antisepsis in Phthisis.** *Lancet, February* 11, 1888.

NOTHING new. **Hunter Mackenzie.**

STEPHENS, LOCKHART (Emsworth).—**Treatment of Tracheal Cough.** *British Medical Journal, April* 14, 1888.

INHALATIONS of pinol, twenty to thirty drops, to be placed on a pledget of absorbent cotton in a hot water inhaler, and used for ten to fifteen minutes three or four times daily. **Hunter Mackenzie.**

HARNACH.—Aqua Calcis. *Berl. klin. Wochenschr.*, 1888, *No.* 18.

RECOMMENDATION of gargling with this medicament in cases of diphtheria. **Michael.**

On Poisoning by Antipyrin. *Lancet, February* 25, 1888.

AMONGST the symptoms were irritation of the nasal fossæ, and hoarseness of the voice. In a second case the "inside of the throat was obstructed to such an extent that for six hours the patient was threatened with suffocation." A medicinal exanthem, of the nature of urticaria, is not unfrequently developed in these cases. **Hunter Mackenzie.**

DIPHTHERIA.

JACOBI, A. (New York).—**Therapeutics of Diphtheria.** *Medical News, June* 16, 1888.

DIPHTHERIA is a contagious disease. Severe forms may beget mild or severe forms. Mild cases may beget mild or severe cases. There is

probably no spontaneous origin of diphtheria. What has been called follicular amygdalitis (or tonsillitis) is diphtheria in many, perhaps most cases. It is seldom dangerous to the patient, because the tonsils have very little lymph connection with the rest of the body. But the diphtheritic variety of follicular amygdalitis is contagious. This mild variety is that from which adults are apt to suffer. Wherever suspected it ought to be looked after, isolated and treated. Preventive treatment should occupy a pre-eminent place. All diphtheria, mild or severe, should be isolated ; and attendants upon such cases should not have intercourse with healthy persons. Children of the same family should not go to school or church. A family with children ought to insist upon occasional inspection of the throats of servants, or persons coming to the house for occasional employment. In times of epidemic every public place ought to be treated like an hospital, and disinfection carried out at regular intervals. Vehicles should also be disinfected. To what extent diphtheria may cling to surroundings is best shown by the cases of diphtheria springing up in premises which had not seen diphtheria for a long time. When a diphtheritic case has been for long in a room, everything in it becomes infected. If barely possible, a child with diphtheria ought to change its room and bed every few days. As diphtheria will not as a rule attack a healthy surface, endeavour should be made to keep the mucous membrane in a sound condition. This especially applies to the throat and nose.

Tincture of pimpinella saxifraga is an efficient remedy in subacute and chronic pharyngitis and laryngitis. Large tonsils should be resected. Glandular swellings in the neck must not be tolerated. Every eczema of the head and face, every stomatitis and rhinitis, should be relieved at once. Chlorate of potash or sodium for the mouth, is a preventive remedy.

Cases of pharyngitis or stomatitis accompanying the presence of membranes are benefited by the local and general effect of chlorate of potash. Tonsillar diphtheria runs its course in four to six days.

Not more than fifteen grains of chlorate of potash should be administered as a dose for an infant a year old, and not over twenty or thirty grains for a child from three to five years old, in twenty-four hours. An adult should not take more than one and a-half drachms daily. Repeated doses at short intervals, and not single large doses, should be given, in order to avoid chlorate of potash poisoning.

There is no specific for diphtheria. It requires judgment to know when initial high temperature should be reduced (by sponging, warm or cold bathing, antipyrin, antifebrin, or carbamide of quinia subcutaneously). Convulsions may require chloroform inhalations, or hydrate of chloral per rectum. Vomiting or cerebral symptoms may require liquids or opiates. A very quick and feeble pulse may require a few large doses of a cardiac stimulant, digitalis, stropanthus, sparteine, etc., in the very beginning.

Renal complications and albuminuria occur early, and most cases terminate favourably. It cannot be foretold whether this will be the result ; and milk or farinaceous diet, plenty of water, or Poland, Bethesda, Seltzer,

Vichy or Apollinaris water, warm bathing, warm feet, a few good doses of calomel, a number of hourly or two-hourly small doses of opium (better than digitalis and nitro-glycerine) are indicated. If diffuse nephritis occur it must be treated *secundum artem*. As to local treatment, Dr. Jacobi is best pleased with iodol or iodoform powdered; or one part with eight or ten of vaseline. Subnitrate of bismuth, boric or salicylic acid with starch (one part in fifteen—twenty-five of starch) are very beneficial. Diphtheritic conjunctivitis requires ice bags, with frequent instillation of saturated solution of boric acid with or without atropia. Local treatment of pseudo-membranes of the fauces is of great importance. Membranes on the tonsils do no harm, and should not be treated energetically. Forcible brushing often tears or scratches healthy tissue, and causes the spread of the membrane. Nasal injections can be made to wash the posterior pharynx and tonsils sufficiently, and are easier and less objectionable than opening the mouth forcibly. The membranes may also be brushed with tincture of iodine several times daily, or a drop of concentrated carbolic acid. There is only one powder—calomel—which is not contra-indicated. Even this may be irritant. Whatever has a bad taste or odour, *e.g.*, sulphur, iodoform, or quinia, must be abhorred. Papayotin, in two or four parts of water and glycerine, may be applied in the nose, throat, and through the tracheotomy canula. Steam will aid in liquefaction and throwing off of the membranes. Its action is best the greater the amount of muciparous follicles under cylindrical or fimbriated epithelium. It is best in tracheo-bronchial diphtheria—so called fibrinous bronchitis. Where the epithelium is permanent, and but few muciparous follicles are present, and the membrane is firmly coherent, *e.g.*, tonsils and vocal cords, moist heat tends to favour extension of the process. The steam may be medicated with ol. terebinthinæ or carbolic acid. Drinking large quantities of water, or water mixed with alcoholic stimulant must be encouraged. The pseudo-membrane is more easily made to macerate over a thoroughly moistened mucous membrane. For this purpose jaborandi or pilocarpine was recommended by Guttmann as a panacea. There are few cases in which it can be tolerated long enough to do good. It is one of the remedies which "may cure our case and kill our patient" by enfeebling the heart. Diphtheria of the nose is apt to terminate fatally unless energetically and early treated. Disinfection should be pursued. The absorbing surface of the nose is great, and injections should be made every hour, for one or more days. If the nose is much blocked with membrane, a probe with absorbent cotton dipped in 50 to 60 per cent. carbolic acid should be pushed in. Solutions of chloride of sodium, two-thirds of one per cent., saturated solutions of boric acid, one part of bichloride of mercury, thirty-five of chloride of sodium, and five thousand of water, or lime water, or solutions of papayotin, will be found satisfactory injections to dissolve the membrane. A stout glass syringe, with rubber mounting in front, is the best injector. Carbolic acid requires care, for fear of poisoning. When children cannot be raised, the same solutions may be used with a spoon or atomizer. For a day or two these injections must be made hourly, and children must be wakened up for them. On the successful and proper syringing and spraying of the nose

depends the life of every patient with nasal diphtheria. The development of bacteria is prevented by solutions of one part of carbolic in 850, and their activity by one in 1,200; so injections need not be concentrated. Diphtheritic adenitis of cervical glands at the angle of the jaw is ominous, and points to nasal and naso-pharyngeal infection. Direct local treatment of the glands, if not entirely useless, is of minor importance. Inunction with the common iodide of potassium ointment is useless; mixed with lanolin, it is readily absorbed. Iodoform may be used in the same way. The best treatment is that directed to the absorbing surfaces. If suppuration occur, incisions, free scooping, and carbolic acid must be employed. If there is hæmorrhage, solutions of carbolic acid or perchloride of iron must be avoided.

Heart failure must be treated by absolute rest, digitalis, strophanthus, spartein, camphor, alcohol, and musk. Feebleness or collapse must not be waited for.

Alcoholic stimulants ought to be given early. Even mild cases are accompanied with heart failure. Coffee is a good stimulant, or 5 to 25 grains of camphor. If rapid effect is aimed at, camphor in olive oil (1 in 5) is a milder and more convenient subcutaneous injection than ether. The best internal stimulant is Siberian musk. When 10 or 15 grains, given to a child of one or two years old, will not accomplish a satisfactory effect within three or four hours the prognosis is very bad.

Post-diphtheritic paralysis yields to digitalis and cardiac tonics and mild preparations of iron, nux vomica and strychnine. Local frictions, massage and continuous or faradic currents are adjuvants.

Dr. Jacobi eulogizes chloride of iron. An infant of a year old may take forty-five or sixty-five grains a day; a child of three or five years old, 120 to 180 grains. It should be mixed with half to a teaspoonful of water (a drachm in four ounces allows half a teaspoonful every twenty minutes), no water must be drank after it. A good adjuvant is glycerine. It is rare that it is not tolerated. Cases in which there is much blood-poisoning, unstable stomach, feeble heart, and frequent pulse, those in which alcoholic stimulants are essential, are better off without iron.

Dr. Jacobi is a strong advocate for internal administration of mercury. The dose is $\frac{1}{60}$th to $\frac{1}{40}$th grain of the bichloride diluted in a teaspoonful of water or milk, given every hour. A baby a year old may take half a grain every day for many days in succession. As a gargle or local application it may be used in strength of 1 to 2,000 to 3,000, or less. Operation for laryngeal stenosis is often obviated by this drug, and it is particularly effective in laryngeal diphtheria. Even desperate cases will get well with bichloride of mercury.

[We have abstracted this paper of Dr. Jacobi's at considerable length, because the author is a well-known authority upon the subject, and because we have frequently been asked for indications for treatment in diphtheria. These are well laid down in Dr. Jacobi's paper; and though some of his opinions may be open to criticism, he speaks from a very large experience, and his remarks are most valuable.]

R. Norris Wolfenden.

O'DONNELL, P. (Chicago). — **Diphtheria during Pregnancy.** *British Medical Journal, February* 4, 1888.

"THE tonsils," says the author, "were so enlarged as almost to meet, and were covered with well-marked characteristic exudation. Temperature 102° F. The attack was a sharp and severe one." The illness and the pregnancy had no apparent effect upon each other.

[No mention is made of the occurrence of post-diphtheritic paralysis. The case seems to have been one of simple tonsillitis.—REP.]

Hunter Mackenzie.

FERNALD, F. C. (Washington).—**Three Unusual Cases of Diphtheria.** *Med. News, November* 5, 1887.

THE cases are described minutely. Case I., Membrane extending from throat to external ear: recovery under trypsin. Case II., Paralysis of the diaphragm: death. Case III., Diphtheria with unique extensive disturbance of sensation. **John N. Mackenzie.**

BEAVER, WHITE (La Crosse, Wisconsin).—**Peroxide of Hydrogen in the Treatment of Diphtheria.** *Med. News, February* 11, 1888. Letter to Editor.

EVEN when cyanosis occurs, relief may be obtained by fifteen to twenty drops (strength of solution not given) of the peroxide internally, diluted with one or more tablespoonfuls of water. The throat should also be gargled or scrubbed with equal parts of peroxide of hydrogen and water, every half hour or oftener. The remedy is not designed to supplant such auxiliary treatment as may be needed, but will be found, in conjunction with other forms of treatment, the nearest approach to a specific of any remedies heretofore used. **John N. Mackenzie.**

CASADESÚS, ROQUER.—Hydrochlorate of Pilocarpine in the Treatment of Diphtheria. *Rev. de Laringologia, Otologia y Rhinologia. June*, 1888.

THE author records the case of a child, aged six, with diphtheritic patches on the mucous membrane of the fauces, lasting four or five days. Croup symptoms then appeared. Pilocarpine and perchloride of iron cured the patient without tracheotomy. Another child was tracheotomized, and under hydrochlorate of pilocarpine, and in three days every trace of false membrane had disappeared from the throat. A girl, aged three, in whom both tonsils, uvula, soft palate, and nasal fossæ were coated with false membranes, the sub-maxillary glands were enlarged, and fever was intense. The case was cured in a few days with hydrochlorate of pilocarpine, perchloride of iron, and local application of lemon-juice. The fourth case was that of a child aged four, feeble, and with tonsillar hypertrophy, in whom were diphtheritic patches on the fauces, croupal cough, difficulty of breathing, enlarged submaxillary glands, and fever. It was treated with ipecacuanha, extract of quinine, and sulphide of calcium; and essence of turpentine was locally applied, and its vapour inhaled, but no good results were obtained.

Hydrochlorate of pilocarpine was also given. In spite of it the asphyxiative period appeared, and tracheotomy was performed. The little patient, however, was still treated with pilocarpine. After three days, broncho-pneumonia supervened, and kermes was given. The patient was cured. Casadesús quotes these cases, in order to make some reflections on them with reference to pilocarpine. He does not consider it a specific remedy for the disease, but thinks that it acts by its peculiar physiological action on the mucous membranes by helping the removal of diphtheritic exudations. **Ramon de la Sota.**

GUELPA.—Nutriment in Diphtheria. *Soc. de Thérapeutique, April* 29.

IN the case of patients suffering from diphtheria, alimentation ought to consist of liquids or semi-liquids, and should be most carefully administered, in proportion to the intensity of the affection and the violence of the inflammation of the throat. By observing these hygienic precautions, and employing frequent irrigations of perchloride of iron, diphtheria ceases to be that discouraging disease which used so often to be fatal.

Joal.

RAVEN, THOMAS F.—The Treatment of Diphtheria and Tonsillitis. *British Medical Journal, March* 24, 1888.

THE writer directs attention to the fact that "exudative tonsillitis" is frequently mistaken for diphtheria. Though infectious, and due to sewer-gas, it is not followed by paralysis, and is very curable.

[There is, doubtless, a lamentable amount of ignorance amongst members of the medical profession regarding the diagnosis of diphtheria. Hence, as the author points out, the number of so-called cures which follow every conceivable line of treatment.—REP.] **Hunter Mackenzie.**

MOUTH, TONSILS, PHARYNX, &c.

HARKIN, ALEXANDER (Belfast).—**Suppression of the Salivary Secretion.** *Lancet, February* 4, 1888.

RECOMMENDS chlorate of potassium in twenty grains three times daily, as a "regulator" of the salivary glands. **Hunter Mackenzie.**

CARLETON, P. M. (Medical Staff).—**Communicability of Syphilis through the Saliva.** *British Medical Journal, February* 4, 1888. See *Journal of Laryngology*, vol. ii., pp. 158 and 235.

AN explanatory note regarding a case in which syphilis was supposed to have been communicated by a tattooer, the subject of *tertiary* syphilis. "There was no lesion in the mouth (of the operator), but there was a muco-purulent discharge from one nostril, and other symptoms of post-

nasal mischief were present. This may no doubt have been the source of the contagion."

[The point, which seems not to have been apprehended by the author, is not whether the saliva may be a medium of contagion, but whether a *tertiary* syphilitic lesion of any kind and in any situation may be a means of communicating the disease.—REP.] **Hunter Mackenzie.**

JOUILLARD. — Cancer of the Sub-maxillary Gland. *Thèse, Paris*, 1888.

CANCER, adenoma, and adeno-chondroma are the solid tumours of this gland. It occurs under the form of sarcoma, adenoma, and epithelioma, with nearly the same frequency. The purity of the cancer is the rule, the complexity the exception. There are no absolutely distinctive symptoms. In most cases the symptoms in the course of the disease are those of a benign tumour. Generalization is exceptional. Diagnosis is often very difficult, and it is sometimes impossible to recognize the glandular origin and malignant nature of the disease. Prognosis is much less grave than in cancer of other salivary glands ; exceptionally inoperable, it does not appear to have any tendency to recurrence. It is an excellent study of the subject. **Joal.**

THOMSON, P. J.—Case of Scald of the Tongue and Floor of the Mouth by the Bursting of a Roast Chestnut. *Lancet, February* 25, 1888.

THE title indicates the nature of the case. **Hunter Mackenzie.**

DICKINSON, HOWSHIP W. (London).—**The Tongue as an Indication of Disease. (The Lumleian Lectures delivered at the Royal College of Physicians.)** *British Medical Journal, March* 24 *and* 31, *April* 7, 1888.

IN these discourses it is, according to the lecturer, not his purpose "to deal with ailments local to the organ, but only with those changes which have their origin outside it, or belong to the system at large. I look at the tongue as a physician, not as a surgeon, and regard it as symptomatic of disease rather than as the seat of it." The lecturer proceeded to describe in detail the various kinds of tongues according to a classification based upon their naked-eye and microscopical characters, for which the reader is referred to the published lectures. **Hunter Mackenzie.**

LOVERIDGE, ARTHUR W. (Newport, Mon.). — **Herpetiform Eruption in Tonsillitis.** *British Medical Journal, April* 14, 1888.

NOTHING of importance. **Hunter Mackenzie.**

RUAULT, A.—Some Reflex Neuropathic Phenomena of Tonsillar Origin. *Archiv. de Laryngol., April*, 1888.

IF a galvano-cautery bulb, the size of a pea, be applied to the centre of the tonsil, an intense pain is often provoked in the corresponding ear. If the cautery point is carried towards the inferior extremity, other reflexes

are determined, such as spasmodic cough, vomiting, gastric pains. Chronic inflammation of the tonsils seems to suffice in some people to produce these phenomena, and one finds in such persons intermittent otalgia, buzzing in the ears, attacks of coughing, bronchial asthma, and vomiting. These different symptoms may disappear after a destruction of the tonsils, leaving no doubt that tonsillar hypertrophy may be the cause of them; and so far as regards aural troubles, Ruault relates four cases, in which hearing was ameliorated by the application of the galvano-cautery to the hypertrophied tonsils. Two cases are related of spasmodic cough, which disappeared after employment of ignipuncture of the tonsils, and two cases of continual hawking cured by the same treatment. Ruault also cites a case of asthma of tonsillar origin, and relates a case of a child of eight years of age, affected with tonsillar hypertrophy, who vomited frequently without any appreciable gastric affection. Treatment of the tonsils has cured the condition. **Joal.**

COROMINAS, E.—Cure of a Large Tonsillar Hypertrophy by a Scarlatinal Angina. *Revista de Cicencias Medicas de Barcelona, May* 10, 1888.

A GIRL, aged two years, had both tonsils as large as great walnuts, when she was attacked with a violent sore throat during scarlet fever. The mucous membrane was red, dry, and shining, with a few scattered whitish patches. On the fourth day of the disease, Corominas examined the throat, and observed with astonishment that the tonsillar hypertrophy had disappeared, and there were no signs of ulcers or eschars. She was cured of the attack of scarlet fever, and afterwards remained free from tonsillar enlargement. **Ramon de la Sota.**

WRIGHT, JONATHAN (Brooklyn).—**The Galvano-Cautery in the Treatment of Enlarged Tonsils.** *Med. News, March* 24, 1888.

LETTER to the editor strongly recommending ignipuncture.

John N. Mackenzie.

VON HOFFMANN, H. (Baden Baden).—**The Treatment and Prophylaxis of Angina Tonsillaris.** *Med. News, Nov.* 26, 1887.

HE defends the theory which attributes the disease to the action of germs in the gland ducts. The treatment consists in applying pressure (squeezing) to the tonsils (from below upward), with a wad of cotton wrapped around the point of a dressing forceps and dipped in a mixture of equal parts of tincture of iodine and glycerine. Some pain attends the operation, but the relief is very great. Gargles of potash and large doses of quinine assist the cure. In order to avoid future attacks, a blunt hook or tenaculum should be carried over the tonsils from above downward, when it will be felt to enter the depressions in the gland caused by previous attacks of tonsillitis. The tenaculum is allowed to sink to the base of the depression, and is then made to "perforate the mucous membrane, allowing the opening to appear on the oral mucous membrane, and then with a quick motion tear through the intervening membrane; by this means the cavity or recess becomes converted into a

slit or cleft, which during every act of swallowing thereby empties itself, so that no inflammatory products can attach themselves." In some cases it may be necessary to remove a part or the entire tonsil ; in others, only a piece of the membrane. For removal of the tonsil, a long hooked forceps, a tonsil bistoury, a pair of curved scissors for the purpose of cutting down to the base of any pus passage, are necessary. Chronic redness of the gums is said to be a symptom, which always coexists with, and is positive proof of, pus accumulations in the tonsil. Galvano-cautery and scarification are beneficial, but the good result is due more to "blind luck" than anything else. The formation of a scar is also dependent upon chance, for after the cautery is used it is not always that cicatrization readily occurs, owing to the continual contraction ; and even if the scar is well formed, it is often the cause of development of a new recess, which, on account of the scar tissue, is not easily laid bare. Against tonsillotomy is urged the fact that more of the secreting membrane is removed than is the case with the cautery, and that after the removal of the tonsil it is still necessary to look for open cavities, which are necessarily left after tonsillotomy. Partial excision, to lay bare a deep cavity behind the gland, is often demanded, but this is more easily reached with the blunt hook. **J. N. Mackenzie.**

FELICI, F. — Granuloma, or Sarcoma of the Pharynx. *Il Morgagni*, 1888.

A CONTRIBUTION (with historical review) to the differential diagnosis between syphilis and sarcomatous growths of the pharynx, a syphilitic condition having preceded this. A large tumour springing from the posterior wall of the pharynx covered the arytenoid cartilages. The tumour, after some traction, was pulled out spontaneously, and the microscopical examination showed it to be of a sarcomatous nature. The patient died shortly after. In consequence of the coexistence of syphilis, the recognition of the true nature of the disease was certainly not easy. **Massei.**

NOSE AND NASO-PHARYNX.

WALSHAM, W J. (London).—**A New Method of Applying the Nasal Truss for Correcting Deformities of the Nose.** *Lancet, February* 25, 1888.

A DESCRIPTION of apparatus. **Hunter Mackenzie.**

"COUNTRY PRACTITIONER."—The Treatment of Intractable Rosaceous Nose. *British Medical Journal, February* 11, 1888.

A RECOMMENDATION of scarification, which is said to be not at all a painful process. **Hunter Mackenzie.**

SANDFORD, ARTHUR W. (Newcastle-on-Tyne).—**Case of Persistent Sneezing.** *British Medical Journal, March* 17, 1888.

A PATIENT, aged ten years, sneezed continuously for ten days, with the exception of a few hours' sleep on three nights. No effect was produced by bromide or iodide of potassium, galvanism, chloroform, or counter-irritation.

Hunter Mackenzie.

ZIEM (Dantzig).—**Genesis of Facial Erysipelas.**—*Dtsch. Med. Wochenschr.*, 1888, *No.* 19.

ERYSIPELAS is often caused by purulent processes of the nares and jaws without complication of external infection. Such affections, therefore, must be treated carefully.

Michael.

COZZOLINO, PROF. V.—A Large Calculus in the Left Nasal Cavity. *Archiv. Italiano de Laringologia.*

MASSINI, G.—A Calculus in the Right Nasal Cavity. *Gaz. degli Ospitali.*

NASAL calculi are somewhat rare, and the two cases related by the two Italian specialists are full of interest. The one observed by Cozzolino was very large. The diagnosis in both cases was only possible by means of the metal probe. The stone was composed of triple phosphate, and neutral carbonate of lime. No chemical examination was made of the one extracted by Massini. It originated in a small stone, which the patient, a child aged ten, had introduced into the nose five or six years before. He was emaciated, but soon recovered after the calculus was removed. Cozzolino's patient was a man aged sixty, and besides the purulent discharges from the nose he complained of deafness and noises in the left ear.

Massei.

PLATT, W. B. (Baltimore).—**Fibro-adeno-Sarcoma of the Naso-Pharynx.** *Med. News, June* 2, 1888.

A DETAILED account of the interesting case of a negress, aged forty-four, who had complained of stoppage of the nose, sore throat, constant pain in the temples, and bleeding from nose and throat. The growth, which filled the naso-pharynx, was removed by first dividing the velum, and then slowly separating the growth from its attachment by the snare. Hæmorrhage was steady but moderate, and easily checked. The incision in the palate was closed with six silver sutures, and healing took place by first intention. The sutures were removed in five to nine days. At the end of four weeks articulation was nearly normal, and deglutition performed with ease. For three to four weeks there was some induration at the former site of the tumour, which gradually disappeared.

John N. Mackenzie.

D'ANTONA, PROF. A.—Enormous Fibro-Sarcoma of the Left Nasal Cavity. *Rev. Clin. della Universita di Napoli.*

THE patient, a countryman aged thirty-six, had been ill for only three months, and was operated upon for a growth of the left nasal cavity; soon after he noticed a large growth at the back of the velum. There was

exophthalmos ; the nose was large, and a growth issued externally from the left nares. A tumour like a small citron was visible in the pharyngeal cavity. A longitudinal incision from the left external aperture of the nares was made with the bistoury, extending to the outer canthus of the eye ; the zygoma was cut with scissors, as well as the corresponding part of the right superior maxillary bone. The whole bone was dislocated, and the nasal bones of the left side taken out. Considerable hæmorrhage occurred. The operator with the hand quickly removed the whole tumour. Recovery speedily followed. **Massei.**

HEYDENREICH.—New Method of Removing Naso-Pharyngeal Polypi. *Semaine Méd., May* 9, 1888.

THE author explains König's method of removing polypi with a sharp spoon, after preliminary division of the nose in the median line. He advises great circumspection in resorting to this method. **Joal.**

LARYNX.

MACKENZIE, G. HUNTER (Edinburgh).—**Case of Chronic Laryngitis, probably Tubercular, treated by Tracheotomy and by Endo-laryngeal Removal of Growth** *British Medical Journal, February* 4, 1888.

RECORD of a case with substantial improvement following the operation of tracheotomy, and in which a small warty-looking growth was removed from the vocal cord. **Hunter Mackenzie.**

LOEWE (Berlin).—**On the Removal of Pathological Secretions of the Larynx by Forced Injections of Water.**—*Monatssch. für Ohrenheilk.*, 1888, *No.* 5.

THE author cleanses the larynx by forced injections, and says that this method has been performed by him in many cases with good results. **Michael.**

STEELL, GRAHAM (Manchester).—**Spontaneous Detachment of a Laryngeal Polypus.** *British Medical Journal, February* 4, 1888.

NARRATION of a case. **Hunter Mackenzie.**

AUDUBERT.—Cyst of the Ventricular Band. *Rev. Mens. de Laryngol., April*, 1888.

THE author relates a case seen at the clinic of Prof. Moure. Cysts of the ventricular bands are very rare. Garel, of Lyons, and Seiffert have each related similar cases, and the observation now published is the third case known. **Joal.**

KIDD, PERCY (London).—**A Case of Angioma of the Larynx.** *British Medical Journal, March* 17, 1888.

A CASE in which an angiomatous growth, attached to the anterior third of

the left vocal cord, was removed by endo-laryngeal means. The author remarks upon the rarity of angioma of the larynx. **Hunter Mackenzie.**

URUNUELA.—Fibrous and very Voluminous Laryngeal Polypus, which filled the Supra-glottic Region; Aphonia; Imminent Danger of Death by Asphyxia. *Revista de Laringologia, Otologia y Rinologia, May,* 1888.

A MAN, forty-five years old, suffered intense catarrh. Four years previously his voice was hoarse, and for one year he had been completely aphonic, and experienced frequent fits of suffocation. For the last two months he had been unable to lie down, and has always been obliged to keep his head bent forwards, and to lean upon the back of a chair. Many times he suffered from an exceedingly troublesome cough. On laryngoscopical examination, there was found a pyriform and non-mammillated growth, the size of a hazel-nut, which almost obstructed the glottis. It was seen to be growing from the anterior end of the right vocal cord. The author removed the polypus with the Mackenzie forceps. The operation was attended with a slight hæmorrhage, and a good respiration was restored. Only a small fleshy point remained, which was exterminated with the galvano-cautery. After a month the patient was discharged, the voice and respiration being fairly good. **Ramon de la Sota.**

SOTA.—On the Measures to be followed in Intubation of the Larynx in order to Avoid its Difficulties. *El Siglo Medico, June* 24, 1888.

THE author describes the instruments used to perform intubation, and then the manner of procedure. He advises that the tube be adapted to the age and size of the child; and in case of doubt selects the largest one. The silk must be strong, and a metre long. The obturator must be screwed tightly to the introducer. The child should be wrapped in a sheet, its feet held between the knees of a competent person, who will sustain it seated upon his thighs, with its trunk resting on his chest and its head upon his left shoulder. Another person must keep this steady, and directed a little backwards. The operator will cover the index finger of his left hand up to the junction of the first with the second phalanx. A piece of the finger of a glove is the best. Sota introduced the tube according to O'Dwyer's rules, but he does not approve of Waxham's advice to bear the instrument under the finger. When the tube is well located, the thread is taken away before cutting it near to the teeth, and putting the index finger upon the head of the tube. The little patient cannot drink whilst the tube is in the larynx. That must be removed if the respiration is troublesome, or six days after intubation. If dyspnœa appears, the tube must be introduced. **Ramon de la Sota.**

WALDO (Bristol).—**A Case of Intubation of the Larynx in the Adult.** *British Medical Journal, April* 7, 1888.

A SUCCESSFUL case of intubation in a woman, aged forty-two years, the subject of tertiary syphilis. **Hunter Mackenzie.**

NORRIS WOLFENDEN, R. (London).—**Perichondritis of the Larynx.** *British Medical Journal, April* 14, 1888.

A STRONG non-syphilitic man, aged forty-three, applied at the Throat Hospital on account of laryngeal troubles. On laryngoscopic examination there was found a smooth red swelling, situated under and projecting from beneath the anterior third of the right vocal cord. The cord was congested, and did not move on deep inspiration. The general appearance of the larynx was that of chronic laryngitis. Within eight days tracheotomy became necessary. Two days subsequently it was seen that the whole larynx was occupied by red swellings, without apparent ulceration; the breath was offensive. Nine days after the operation a small piece of cartilage was expectorated. The patient commenced to improve soon afterwards, and the intra-laryngeal swellings diminished. He was soon dismissed from hospital, but returned in a few days, bringing with him a piece of bone, which he stated he had expectorated.

The patient had an up and down course for a few weeks, necessitating the local application of ice to the larynx on account of fresh inflammatory disturbances, which, however, soon subsided. Mechanical dilatation of the laryngeal passage was afterwards practised with good results, and within four months from the date of tracheotomy he was able to dispense entirely with the tube.

The author makes some observations upon the conditions of the larynx which may be associated with perichondritis, and adds, "the case I have here recorded shows how it (perichondritis) may arise out of chronic laryngitis, and the same catarrhal condition which leads to production of innocent neoplasms may also lead to perichondritis of the laryngeal cartilages."

Hunter Mackenzie.

JURIST, LOUIS (Philadelphia).—**A Case of Perichondritis of the Cricoid Cartilage.** *Med. News, November* 5, 1887.

THE history and post-mortem appearances of a case, obscure in its etiology, but supposed to be due either to a rapid acute perichondritis or a late syphilitic infiltration. Death was due to prolonged laryngeal spasm, a rare though possible cause of sudden death in these cases.

John N. Mackenzie.

FUSSELL, M. HOWARD (Manazunk, Pa.).—**Fracture of the Larynx.** *Med. News, March* 17, 1888.

A BOY, while catching behind the bat, was struck squarely in the front of the neck by a base ball, coming swiftly as a "foul" from the bat. Hæmorrhage and difficult breathing at once came on, and, in half an hour, unconsciousness. At the end of an hour he was seen in a cyanosed condition, the least manipulation of the larynx causing fearful paroxysms of suffocation, while crepitation of the alæ of the thyroid was distinctly felt. Tracheotomy was at once performed, the congested lungs relieved of bloody, frothy secretion, and the breathing restored by Sylvester's method. Three hours after the operation the patient was doing excellently. Fifteen minutes later the cyanosis deepened, congestion of the

lungs supervened, and respiration stopped abruptly. No post-mortem was allowed.

This is the seventieth case of fracture of the larynx and the fifty-fourth death. The case is unique in its cause and mode of death. Recorded deaths have all occurred suddenly, before tracheotomy, and were generally due to increasing dyspnœa from œdema. Atlee reports a case in which death occurred suddenly from general emphysema. In the above case the breathing was normal just prior to death, as was the pulse. The sudden stoppage of the heart would suggest sudden pressure on the pneumogastrics in the neck. Ether was given, but it is scarcely probable that it could have caused a fatal result, three hours having elapsed between its administration and death. There was no organic heart lesion.

John N. Mackenzie.

ARBOLELLA.—A Case of Aphasia, following Typhoid Fever. *Rev. di Med. y Cirugia Prácticas, June* 22, 1888.

A CHILD, six years old, was attacked with typhoid fever, and on the sixteenth day symptoms of cerebral congestion appeared; these were mitigated, and the patient slowly recovered. But the child remained dumb notwithstanding that the respiratory organs were sound, and the auditory apparatus perfectly intact. It was thought that the cerebral congestion produced some disturbance in Broca's convolution, and that the aphasia would be transient, or it might be the first symptom of a basic meningitis, which would break out unexpectedly.

Ramon de la Sota.

JOUBERT.—Thyrotomy for Foreign Bodies in the Larynx. *Thèse, Paris*, 1888.

THYROTOMY conducts one directly to the foreign body. It permits one to dislodge it, to extract it, and to break it up; preceded by tracheotomy it constitutes an operation free from danger. The author publishes an original observation furnished to him by M. Campenon, who has performed thyrotomy to extract from the larynx a 50-centime piece.

Joal.

LUC.—On Tracheotomy under Chloroform in Children. *Soc. de Méd. Pratique, June* 7, 1888.

THE author employs chloroform, and the slow method of operating, and relates a case operated on successfully in this manner. Joal.

LE DENTU.—Chloroform in Tracheotomy. *Soc. de Chirurgie, May* 20.

LE DENTU reports on an observation of Castin relating to an accident of glottic spasm resulting from the chloroforming of a patient about to be tracheotomized for syphilitic stricture of the larynx, and said it was an unfortunate case, but which must not be taken to contra-indicate the use of chloroform in tracheotomy. These spasms occur in patients who are about to be tracheotomized independently of chloroformization. Ferrier, Schwartz, and Reclus hold the same opinion. Joal.

MacCORMAC, SIR WILLIAM.—Immediate Closure of Tracheal Wounds. *Lancet, February* 4, 1888.

THE author, in supporting some editorial remarks on the immediate closure of tracheal wounds, refers to a case published in the *Lancet*, January 2, 1886, in which the blade of a broken tooth forceps was extracted from the right bronchus. He thinks that, in this case, the suturing of the tracheal and external wounds contributed materially towards success by shutting out the cold air from the lungs, and preventing wound secretions from entering the trachea. **Hunter Mackenzie.**

JESSETT, BOWREMAN F. (London).—**Immediate Closure of Tracheal Wounds.** *Lancet, February* 11, 1888.

RECOMMENDS the practice. **Hunter Mackenzie.**

JONES, TALFOURD (London).—**Tracheotomy performed on an Adult, four years and a-half ago, for Intra-laryngeal Disease: Patient now alive and well, but still wearing Tracheotomy Tube.** *Lancet, February* 25, 1888.

THE nature of the laryngeal disease was not diagnosed.

Hunter Mackenzie.

NECK, &c.

HOVELL, MARK.—The Treatment of Cystic Goitre.

THE author advocates the treatment introduced by Morell Mackenzie in 1872, which consists in tapping the cysts, and, after the withdrawal of the fluid, injecting a solution of perchloride of iron through the canula of the syringe, and allowing it to remain for a certain time, in order to convert the cyst into a chronic abscess. The tube should be introduced into the most dependent part of the tumour, in order to insure proper drainage. The puncture should be made as near the median line as possible, in order to avoid vessels.

For a large goitre, a canula two inches long is sufficient. The most useful sizes are those corresponding to Nos. 7, 8, 9, English catheter gauge. When the canula is in the cyst, it should be secured by a tape passed round the neck. The plug being withdrawn, the contents are allowed to escape, and one or two drachms or more of perchloride of iron (two grms. of the salt to one oz. of water) should be injected into the cavity by the syringe vertically, and the plug should be introduced to prevent the solution from escaping. The syringe has its nozzle fixed at an obtuse angle, and being held vertically allows any air which may be in the syringe to rise to the top of the solution, and thus prevent its injection into a vein. By a button arrangement, the piston can be made about an inch shorter than the cylinder, so as to prevent emptying it. When the solution has been injected into the cyst, it should remain there for seventy-two hours. The cyst will re-fill, and inflammation will be set up. If, on withdrawing the fluid, it contained blood, or showed no sign of suppuration,

the injection must be made as before, and repeated until suppuration is produced. Poultices should then be applied, and the plug be removed. When the process is complete, the cyst may be washed out with water containing some antiseptic. In the subsequent treatment of the case, thorough drainage must be kept up. The rise of temperature shows the canula is blocked. A piece of Ellis' drainage tube, introduced through the canula, ensures perfect drainage. The canula should not be removed until the cyst is contracted round the opening, and granulations have begun to block up its aperture. When this is the case, it should be replaced by a shorter (quarter of an inch) canula, and removed again when granulations block it. If no appreciable diminution in the size of the cyst takes place, and the discharge is thin, tonics and generous diet should be given, and the cyst injected with chloride of zinc (15—30 grs. to the ounce), and allowed to escape again. A multilocular cyst should be treated in the same way as a simple cyst. A cyst containing a large amount of calcareous matter in its walls can only be treated by excision.

The author then gives illustrations, and describes two cases successfully treated. He does not agree with the plan of shelling out nor with the method of antiseptic incision and stitching the edge of the cyst to the skin, scraping the interior, afterwards packing with zinc lotion, as proposed by Mayo Robson. Very little is said in surgical books as to the treatment of cystic goitre: each authority differs, and the practitioner could derive no help from text books. The plan here detailed is the simplest and most efficient surgical procedure, and is the one which has always been successfully adopted at the Throat Hospital.

Norris Wolfenden.

THORNTON, PUGIN (Canterbury).—**On the Treatment of Cystic Goîtres.** *Lancet, February* 18, 1888.

REFERRING to treatment by puncture and injection of iron, the author recommends the substitution of rubber for metal canulæ on the third or fourth day, so as to do away with the risk of irritating the walls of the goître. Hunter Mackenzie.

ORMSBY, GEORGE H. (Slaidburn).—**Congenital Goître.** *Lancet, February* 25, 1888.

SHORT record of a case. Hunter Mackenzie.

CRAN, ROBERT (Upper Assam).—**An Enormous Goître.** *Lancet, February* 18, 1888.

A LAD of eighteen had a goître of the following dimensions:—From the lower edge of the jaw to the bottom of the goître, 15¼ inches; round the thickest part of the goître, 20½ inches. No inconvenience, beyond a dragging sensation, was experienced. Hunter Mackenzie.

PAGE, FREDERICK (Newcastle-on-Tyne).—**Spasmodic Torticollis, following Injury to the Cervical Spine, successfully treated by Stretching the Spinal Accessory Nerve.** *British Medical Journal, February* 4, 1888.

THE title indicates the nature of the case Hunter Mackenzie.

TRESILIAN, FREDERICK (Mon.). — **A Case of Myxœdema.** *British Medical Journal, March* 24, 1888

CONTAINS nothing new. **Hunter Mackenzie.**

LAYCOCK ROUTH, R. (Banbury).—**Hæmorrhage as a Symptom attending Myxœdema.** *Lancet, February* 4, 1888.

Hæmoptysis was the form of hæmorrhage. **Hunter Mackenzie**

REPORTS OF SOCIETIES.

Royal Academy of Medicine in Ireland.

PATHOLOGICAL SECTION.

February 17, 1888.

Dr. E. H. BENNETT.—*Rupture of the Trachea with Fracture of the Sternum and Rib.*

THIS specimen was taken from the body of a man who had been fatally crushed. There was no external wound, but blood had poured from the mouth. The trachea was ruptured transversely, and the fragments were separated by an interval of an inch. The œsophagus was bruised, but not torn; there was great effusion of blood around the trachea and œsophagus, but none of the great arteries or veins were ruptured. **Hunter Mackenzie.**

SURGICAL SECTION.

January 20, 1888.

Mr. FOY.—*The Surgery of the Thyroid Gland.*

CONDEMNATION was expressed of the many minor operations of setons, caustics, injections of irritants, and tapping. A case of successful removal of a cysto-adenoma from the right lobe of a young married woman was recorded.

The PRESIDENT (Dr. Corley) referred to the recommendation of Dr. P. H. Watson, that complete removal of the gland be practised.

Mr. KENDAL FRANKS did not think that the size of a tumour in the neck was a guide to operative procedure, for occasionally small tumours pressed backwards and downwards under the top of the sternum, caused great dyspnœa, and endangered life.

Mr. W. THORNLEY STOKER's experience in operating was, that the operator must be prepared for terrible hæmorrhage. He condemned the passing of a seton through the gland. He had been unable, in his operations, to find the capsule of the gland.

The PRESIDENT had seen cases of acute goitre cured by quinine.

Mr. FOY, in reply, mentioned several conditions which justified the operation of removal. He considered Sir Morell Mackenzie's method of injecting perchloride of iron as most unsuitable. **Hunter Mackenzie.**

British Medical Association: Metropolitan Counties Branch: North London District.

March 28, 1888.

Mr. F. DURHAM.—*Tumour of Neck pushing Trachea and Larynx to Opposite Side.*

CASE shown.

Mr. BLACK.—*Ulceration of Tongue: Epithelioma.*

CASE shown. Hunter Mackenzie.

British Medical Association: Metropolitan Counties Branch, South London District

February 4, 1888.

Dr. TREVELYAN.—(1) *Tubercular Ulceration of Epiglottis.* (2) *Syphilitic Disease of the Larynx.*

EXHIBITION of cases, with subsequent discussion. Hunter Mackenzie.

British Medical Association: Birmingham and Midland Counties' Branch.

February 24, 1888.

Mr. BARLING.—*Simple Stricture of Œsophagus.*

EXHIBITION of specimen from a man aged sixty, who had suffered from pain and difficulty in swallowing for four months. The stricture was close to the cardiac orifice and encircled the œsophagus, extending vertically for about three-quarters of an inch. There was some destruction of the mucous membrane, with simple inflammatory thickening of the coats. The cause was unknown.

Hunter Mackenzie.

British Medical Association: East Anglian Branch: Essex District.

March 23, 1888.

Dr. DOWNES.— *Remarks on Epidemic Diphtheria in Rural Districts.*

PAPER read, but not reported. Hunter Mackenzie.

British Medical Association: Adelaide and South Australian Branch.

March 17, 1888.

Dr. GARDNER.—*Excision of Cancerous Larynx.*

RECORD of a case in which the entire larynx had been successfully removed for carcinoma. The author believed that the want of success in Great Britain was largely due to climatic causes.

Dr. LENDON.—*Double Mouth.*

ACCOUNT of a male infant who had two mouths, separated posteriorly by a central pillar of the fauces, and leading into a common pharynx. Anteriorly there was a common buccal orifice. There were two tongues, which moved independently, and two pairs of jaws, considerably distorted in parts. There was a third central nostril. The division of the larynx was doubtful. Hunter Mackenzie.

British Medical Association: Nova Scotia Branch.

January 12, 1888.

Dr. SLAYTER.—*Cocaine Poisoning.*

AFTER subcutaneous injection of fifteen minims of a ten per cent. solution the

patient became cyanosed, and developed an epileptiform fit. He had not previously suffered from epilepsy.

Dr. CAMPBELL.—*Detached Septum Nasi.*

THIS was due to a blow, and was removed from a patient on plugging the posterior nares for epistaxis. **Hunter Mackenzie.**

Pathological Society of London.

February 21, 1888.

Mr. CHAVASSE.—*Mixed Tumour of Parotid.*

SPECIMEN shown, weighing twenty ounces. The tumour has existed for a great number of years, had grown slowly at first, but afterwards more rapidly. It was successfully removed by operation. Mr. Chavasse thought it was due to misplaced aural cartilage, which, acting as an irritant, had led to adenomatous growth from the parotid.

Mr. STEPHEN PAGET supported the view of embryonic origin. As in this instance, most of the cases reported had been in women. **Hunter Mackenzie.**

March 6, 1888.

Mr. W. S. COLMAN, *Diphtheria of Fauces and Larynx, with Acute Inflammation of Peyer's Patches.*

CARD case. **Hunter Mackenzie.**

March 20, 1888.

Mr. TARGETT (for Dr. FRY).—*Cystadenoma of Thyroid.*

CARD specimen. **Hunter Mackenzie.**

April 3, 1888.

Mr. COLMAN.—*Intestines in Diphtheria.*

SPECIMENS from three cases were exhibited. The spleen was not enlarged, and the œsophagus and stomach were healthy. Peyer's patches and the solitary glands, as also the mesenteric glands, were enlarged, and all the lymphoid structures were injected.

Dr. WILKS thought that the cases illustrated how much there was in common in the various specific fevers. The condition of the intestinal glands in diphtheria closely resembled that seen in typhoid fever.

Dr. COUPLAND referred to the fact that Dr. Vandyke Carter had seen ulceration of the glands, and remarked that this observation tended to break down the sharp distinction which had been drawn between the morbid process in the intestines in typhoid and in other specific fevers.

Mr. COLMAN remarked that he had not seen ulceration. He quoted Dr. Barlow, who, in one case of uncomplicated diphtheria, had seen intestinal ulceration.

Dr. FELIX SEMON and Mr. SAMUEL G. SHATTUCK.—*Malignant Disease of the Air-Passages.*

THREE cases were submitted. The first was one of alveolar sarcoma of the larynx in a man aged eighty-one. The patient would not submit to tracheotomy, and death took place from asphyxia. The second was a man aged fifty-seven, with epithelioma of the right half of the larynx, and an epitheliomatous insula on the left vocal cord. Sir William MacCormack performed extirpation of the right half of the larynx. The patient died from pneumonia on the third day after

the operation. The presence of the malignant affection on the under surface of the left vocal cord was only ascertained at the time of operation. The third case was one of intra-tracheal carcinoma, continuous with carcinoma of the thyroid, in a man aged thirty-nine. The symptoms were compatible with the diagnosis of tubercular disease of the lung and trachea, but no bacilli were found in the sputum. Death ensued from increasing hæmoptysis.

Mr. GODLEE mentioned two cases of thyroid tumours in which the secondary tumours were situated in bone.

Mr. PITT, referring to the question of the transmission of malignant disease by contact, *e.g.*, from one vocal cord to the other, as possibly in the second of the above cases, remarked upon the frequency with which growths, secondary to malignant disease of the abdominal viscera, occurred in Douglas's pouch.

Dr. HANDFORD.—*Mediastinal Tumour involving the Heart.*

THE specimen was taken from a man at forty-five, who had complained of cough for six months and a half, and latterly of dysphagia, ending in complete inability to swallow. He died from slow hæmoptysis. A mediastinal carcinoma was found after death, which involved the lower lobe of the left lung. The left auricle was also implicated, and there was an irregular sloughy cavity between the roots of the lungs, with which the trachea and bronchi freely communicated. The œsophagus was not involved, and was not strictured, but communicated with the same cavity by three openings. Secondary growths were present in the liver.

Hunter Mackenzie.

Mr. SHATTUCK.—*Recurrent Sarcoma of Thyroid, associated with Hypertrophy of Accessory Thyroid.*

Mr. PITT.—(1) *Caseous Gland ulcerating into Œsophagus and Stomach by Numerous Openings.* (2) *Hypertrophy of Œsophagus associated with Hypertrophied Heart.*

CARD specimen.

Hunter Mackenzie.

Clinical Society of London.

February 10, 1888.

Dr. FOX.—*A Girl with a Chancre on the Lip.*

EXHIBITION of patient.

Hunter Mackenzie.

February 24, 1888.

Mr. J. T. MORGAN.—*Lymphangiectasis of Upper Lip.*

LIVING specimen.

Hunter Mackenzie.

March 9, 1888.

Dr. HADDEN.—*Dry Mouth, or Suppression of the Salivary and Buccal Secretions.*

NO cause could be assigned for this condition in the case of a woman aged sixty-five. The patient was much benefited by the use of jaborandi. It was suggested that the condition was due to some disorder of the nervous system. The patient's digestion was perfect. When the mouth became moister later on, the saliva was acid, and exerted no action on a solution of starch.

Hunter Mackenzie.

Medical Society of London.

February 27, 1888.

Mr. BERNARD PITTS.—*Congenital Cysts in Mouth and on Chin.*

EXHIBITION of a boy, aged fourteen, with fluid swellings, one in the middle line

of the chin, and the other in the floor of the mouth. The swellings had been tapped, and had refilled. **Hunter Mackenzie.**

March 24, 1888.

DR. BOREL.—*Extirpation of Goître.*

THE author alluded to the regulating function of the thyroid over the cerebral circulation, and also to the observations of Kocher, who found cretinism induced by the removal of the thyroid in very young people, the danger being less after puberty. He objected to interstitial injection of iodine, compression, and shampooing, as also to punctures in real hypertrophy. Operation was contra-indicated on account of hæmorrhage. In operating in cases of *goîtres plongeants* (retro-sternal struma), it might be necessary to dissect down to the arch of the aorta, enucleation being done with the finger and scalpel handle. He had never seen myxœdema follow the operation. The dangers of the operation were :—(1) Entry of air into the veins ; (2) Primary arterial hæmorrhage ; and (3) Asphyxia from compression of the softened trachea.

MR. LENNOX BROWNE's experience of the seton was, that the relief was not permanent. He had six cases which he had treated by the removal of the middle portion of the gland, and of the isthmus if enlarged.

MR. BERNARD PITTS mentioned two cases, in one of which he had prevented imminent death from asphyxia by slitting up the tumour ; and in the other, after a difficult tracheotomy, he had removed the gland with comparative ease. The latter patient died of cellulitis. **Hunter Mackenzie.**

March 26, 1888.

DR. ORWIN.—*Lupus of the Mouth, Pharynx, Larynx.*

EXHIBITION of a woman aged twenty-one, in whom lupus was supposed to have spread through the nose to the palate by lymphatic channels.

MR. LENNOX BROWNE had never seen lupus of the posterior wall of the pharynx. He differed from Dr. Orwin as to the path followed by the lupus. A distinguishing point between lupus and tertiary syphilis was that the latter often attacked the palate, both soft and hard, by extension from the nasal mucous membrane, whereas lupus always extended by the buccal mucous membrane.

[Another distinguishing mark between tertiary syphilis and lupus is, that the latter does not affect the bones.—REP.] **Hunter Mackenzie.**

REVIEW.

Studies in Pathological Anatomy, especially in Relation to Laryngeal Neoplasms. I. Papilloma. By R. NORRIS WOLFENDEN, M.D., Senior Physician to the Throat Hospital, Golden Square, and SIDNEY MARTIN, M.D., Pathologist to the City of London Hospital for Diseases of the Chest, Victoria Park. *London : J. & A. Churchill.*

THE object of this important work is "the production of a series of plates and drawings of specimens, illustrating important pathological facts, of practical value

to the practitioner, both as regards diagnosis, prognosis, and treatment." If the fasciculus now before us—the first of a series—be an indication of the manner in which the authors will execute their task, the result will be the production of a work of great value and rare artistic merit.

In this contribution the authors deal with the subject of laryngeal neoplasms, with special consideration of their etiology, clinical aspects, locality, course and terminations.

As is most fitting, benign growths are first noticed and classified, the division of papillomata being alone dealt with in this issue. These are considered in careful detail, and an accurate and concise account is given of their naked-eye and microscopic appearances and structure.

The accompanying plates, however, are *the* feature of the work. In the part now under notice they are four in number (seven figures), of exquisite and faithful execution, and are accompanied in each instance by a key in which the points of importance are indicated without marring the beauty of the drawings by the insertion of reference figures or numbers.

The volume cannot fail to be of the highest value to the practitioner, and we cordially commend it, not only to the specialist, to whom it ought to be really indispensable, but also to every physician or surgeon who desires to approach the practice of his profession from a scientific stand-point.

NEW PREPARATIONS.

PAPAINE AND COCAINE LOZENGES. T. Christy & Co., London.

Papaine has been frequently prescribed latterly, both for diphtheritic conditions of the throat and in the treatment of dyspepsia. Messrs. Christy have produced an elegant lozenge by combining papaine with cocaine, and one which will undoubtedly be of great service in the treatment of ulcers of the pharynx, tonsils, and other parts, and of cracked and fissured tongue. We can highly commend this preparation as both effective and agreeable.

PAPER FIBRE LINT. Burroughs, Wellcome, & Co.

This new preparation is adapted to most purposes for which ordinary lint is applicable, and should prove a valuable accessory to the treatment of surgical and other wounds. We believe it to be a valuable dressing in cases where there is constant discharge. It is highly absorbent, and is very clean, and is in every way an efficient substitute for ordinary lint.

NOTES.

British Medical Association.

Annual Meeting at Glasgow, 1888.

SECTION OF LARYNGOLOGY AND RHINOLOGY.

President.—FELIX SEMON, M.D.

Vice-Presidents.—G. HUNTER MACKENZIE, M.D.; PETER MACBRIDE, M.D.

Secretaries.—DAVID NEWMAN (Glasgow); A. E. GARROD (London).

Dr. Hunter Mackenzie, Edinburgh, has been elected a Corresponding Member of the Société de Médecine Pratique, of Paris.

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés *d'envoyer un numéro de tout journal* contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Um die rechtzeitige Veröffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W., zu senden.

CONTENTS.

Original Articles, p. 319.—Observations on Exophthalmic Goître (Graves' Disease), by DR. R. NORRIS WOLFENDEN.

New Instruments and Therapeutics, p. 328.—BROICH: Nasal Cleaner. CHOLEWA: Nasal Speculum. KRIEG: Electrical Lamp. SCHEFF: Laryngeal Spoon. BROCKMANN: Tube Forceps. D'HEILY: Treatment of Whooping-cough. DUBOUSQUET-LABORDERIE: Whooping-cough and Antipyrine. SCHNITZLER: Kreolin in Diseases of Mouth, etc. WENDT: Pathology of Pertussis. WIDOWRITZ: Treatment of Whooping-Cough. GRANCHER: Action of Vapours of Hydro-fluoric Acid on Tubercle Bacillus.

Diphtheria, p. 330.—BARNES: Etiology of Diphtheria. BERBIER: Albuminuria in Diphtheria. BROUARDEL and DU MESNIL: Epidemics of Diphtheria. FERÉOL: Insidious Diphtheria. ORY: Salicylic Acid in Diphtheritic Angina.

Nose and Naso-Pharynx, p. 331.—GRAHN: Dacryocystoblennorrhœa and Diseases of the Nose. ROBERTSON: A Plea for the Use of the Rhinoscope. VON KLEIN: New and Illustrative Points in Examination of the Nose and Throat. HOPMAN: Congenital Stenosis.

Mouth, Tonsils, Pharynx, etc., p. 332.—MADELUNG: Malformations of the Face. MILLER: Micro-organisms of the Mouth. EVE: Actinomycosis. LOGAN: Leucoma of Tongue. HOBBS: Nervous Phenomena in Exposure of Anterior Column of the Cord. INGALLS: Retro-Pharyngeal Abscess. BLOCH: Bursa Pharyngea.

Larynx, p. 336.—GOUGENHEIM and PERRIER: Cyst of the Sub-hyoid Region. DESVERNINE: Normal and Pathological Anatomy of the Vocal Bands. GOTTSTEIN: Laryngeal Tuberculosis. MIDDLEMASS HUNT, J.: Laryngeal Phthisis. HERYNG: Curability of Phthisis of the Larynx. HENNIG: Tubercular Tumours of the Larynx. LEWIS: Tracheotomy in Morphine poisoning. SCHNEIDER: On Granulation Stenosis after Tracheotomy. AHRONSON: Dilatation of the Glottis. JELENFFY: Electric Contractility of the Laryngeal Muscles after Death. SAVILL: Hysterical Aphonia. LOEB: Enlargement of the Thymus Gland in Children. BRAMWELL: Anomaly in Stammering.

Neck, p. 340.—BERENS: Angioma of the Thyroid Gland. GAUTIER: Exophthalmic Goitre. CHARCOT: Ibid. RENDU: Ibid. CAMERON: Bronchocele treated by Fluoric Acid. SHAW: Electrical Resistance of the Body in Graves's Disease.

Societies, p. 342.—British Medical Association; Bradford Medico-Chirurgical Society; Sunderland and North Durham Medical Society; West London Medico-Chirurgical Society; Brighton and Sussex Medico-Chirurgical Society; Northumberland and Durham Medical Society; Harveian Society of London; Anatomical Society of Great Britain and Ireland; Royal Medical and Chirurgical Society; Midland Medical Society; Pathological Society of Manchester; Leeds and West Riding Medico-Chirurgical Society; Sheffield Medico-Chirurgical Society; Nottingham Medico-Chirurgical Society; Plymouth and Devonport Medical Society; Seventeenth German Congress of Surgery; French Society of Otology and Laryngology.

Note, p. 354.—A Correction.

SCIENCE IN DIET.

SEPTEMBER, 1888.

ERRORS IN INVALID FEEDING.

The three prime foods of the invalid chamber are doubtless cows' milk, gruels, and meat-soups. As ordinarily administered, these have been pronounced a delusion and a snare. The cows' milk curdles, and may thus do no end of damage. The starch is not acted upon by the secretion of the stomach, and may roll about in this organ for hours, aggravating the fever, causing delirium, and giving rise to no end of unpleasant symptoms. The beef-tea, as commonly made, contains, we are told by authorities, mainly the salts and stimulating principles of the meat.

MILK.

It is constantly pointed out that cows' milk differs from human milk in that the former, when taken into the stomach, forms heavy curds, while the latter only flakes. These curds are often as tough and hard as felt. Upon them the secretion of a disabled stomach may have but little effect. In gastritis, gastric ulcer, and dyspepsia, and in intestinal ulceration, diarrhœa, and peritonitis, these curds have occasioned dire results. In typhoid fever, with the large intestine ulcerated, hæmorrhages have been attributed to them. "I have seen," says Sir William Jenner, "the patient restless, sleepless, or drowsy, his temperature raised several degrees above what it had previously been, vomit a quantity of curd, and at once the restlessness cease, the temperature fall, the skin become moist, and the patient drop into a quiet sleep, and the threatening symptoms vanish with the ejection of the offending material. Or the undigested curds may accumulate in the bowels, inducing flatulent distension and pain in the abdomen, restlessness, and increased febrile disturbance. Under these circumstances, I have seen an enema of thin gruel bring away a large vesselful of offensive, sour, undigested curds. Or, again, the undigested curds may themselves irritate the bowels, and produce, keep up, or greatly increase diarrhœa." But it is significant that the domain of infant feeding is where the dangers from plain cows' milk appear most vividly—and yet milk is the only natural food for infants.

Writers on dietetics are constantly referring to the dangers attendant on the administration of plain cows' milk, and pointing out the best methods of overcoming the difficulties. In case of extreme illness, the best plan, without doubt (for it is the safest), is to predigest the milk; the process of predigestion being now readily accomplished, it only being necessary to add a Zymine Peptonising Powder to each pint of milk, which should be kept warm for twenty minutes.

Milk prepared by this process agrees well with the stomach, will not curdle like plain milk, and is far more nutritious, because more assimilable, than the latter. It is certainly a boon to infants and invalids. It is suitable for all ordinary culinary purposes, and is even miscible with lemon-juice. The bland, soothing properties of milk prepared according to the foregoing directions place it foremost in the list of invalid and infant foods. It may be agreeably sweetened with Kepler Extract of Malt, which is sometimes used alone to make milk suitable for the digestion of infants and invalids.

GRUELS.

Of the two chief digestive ferments in the body that act on starch—the salivary and the pancreatic diastase—neither is often active in febrile diseases. The stomach having no noteworthy action on starch, in such cases gruel may roll about in the organ for hours. Gruels are ordinarily light and pleasant food, and in convalescence may prove of inestimable value; but in severe cases they should certainly be digested before they are given. If to a plate of warm gruel there be added a little Kepler Extract of Malt, the gruel will turn liquid at once, for this Extract liquefies and digests it quickly. When treated in this manner, starchy food becomes admissible. Zymine can also be used to digest starch.

BEEF-TEA.

Dr. Pavy appears to have been "the first to put in active practice the idea of preparing an artificially digested food." Beef-tea is necessarily made with heat, but heat coagulates the albumen of the meat, though the hot and cold water used dissolves out some salts and stimulating principles. The insoluble albumen which is coagulated by heat is therefore what is thrown away when the tea is strained. One writer says: "If our patients are to be given beef-tea, if should be made in such a manner that the real substance of the meat shall be retained. To do this, all that is necessary is to predigest the meat. This may be done by adding ½ drachm of Zymine to each ¼ lb. of meat used. By this means, we shall effect what cannot be brought about by any other means except pepsin."

NOTE.

Milk, Gruels, and Beef-tea are of a delicate flavour, and are most acceptable to patients when prepared with the Fairchild digestive ferments.

Zymine (Fairchild) supplied to the Medical Profession in ½-oz. and 1-oz. bottles, at 20s. and 60s. per doz. Retail prices, 2s. and 6s. each. Zymine Peptonising Powders (Fairchild), in boxes containing 1 doz. tubes, at 1s. 6d. per box, to the Profession. Retail price, 2s. Special terms to hospitals.

BURROUGHS, WELLCOME, & CO., Snow Hill Buildings, LONDON, E.C.

THE

JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. SEPTEMBER, 1888. No. 9.

Contributors of original articles receive Fifty Reprints gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

OBSERVATIONS ON EXOPHTHALMIC GOÎTRE (GRAVES'S DISEASE).

By R. NORRIS WOLFENDEN, M.D. Cantab.

THAT Graves's disease (exophthalmic goître) owns heredity must be now regarded as fully established. The disorder must take its place in the rank of neurotic complaints, since its nervous affinities are as well marked as those of any other well-defined "nervous disease."

Trousseau noted the connection. Pepper saw it in mother and son; and Renoud also. Mackenzie saw it in two sisters. Cheadle recorded its occurrence in an aunt and three nieces. Silva found that in one case the sister was epileptic; in a second case the father died of apoplexy, and the mother was neurasthenic; in a third case the daughter had chorea, and in a fourth case a sister had Graves's disease.

Edward Bull[1] noted that in one case the mother was hysterical, and the sister of the mother had Graves's disease. In a second case the grandmother had had a thick skin, the mother was hysterical and anæmic, suffered from struma, with rapid pulse; a sister of the mother had heart disease, two sisters of the patient had goître and exophthalmos, and were anæmic. Another case was highly instructive. The father of the patient died suddenly from heart disease; a sister of the father died of phthisis. This sister had fourteen children, most of whom had asthma. One other sister died of "cholerine"; one of her children died of phthisis, two others had chlorosis and palpitation,—one of these had six children, all of whom were very nervous and chlorotic. The six sisters of the patient had all rapid pulses and palpitation, one of whom died of apoplexy and one other of cardiac disease.

Osterreicher[2] noted a case in a family with the following extraordinary history:—

A hysterical mother had ten children, two of whom presented no

[1] *Norsk Mag. f. Lagevidensk*, 3 R. X., 3 S. 137, 1880.
[2] *Wien. Med. Presse*, No. 11, 1884.

signs of Graves's disease; but the girl was hysterical and the boy epileptic.

The eldest son, aged sixty-six, had double exophthalmos, with cardiac hypertrophy and enlarged thyroid.

The eldest daughter, aged sixty-two, had exophthalmos, palpitation, and enlargement of the thyroid.

The second daughter, aged fifty-eight, had been hysterical for twelve years, suffers from morphiomania, had had exophthalmos and palpitation.

The third daughter, aged fifty, suffered from palpitation; and afterwards had apoplexy, hemiplegia, and aphasia, *followed in three days by exophthalmos.*

The fifth daughter, aged forty, was hysterical, had double exophthalmos, bilateral hypertrophy of the thyroid gland, and palpitation.

The third son, aged forty-seven, was very nervous, had frequent palpitation, slight exophthalmos, and swelling of the right lobe of the thyroid gland.

The youngest girl had the same symptoms as the last.

The youngest son had very pronounced exophthalmos, and moderate thyroid enlargement.

Three children of the eldest daughter had signs of Graves's disease.

Ross[1] in his great book on nervous diseases, remarks that hereditary predisposition appears to exert a certain amount of influence in the production of the disease, and quotes a case of Solbrig's in which the mother and her boy, aged eight, suffered from the disease, and a case of Hawke's in which the father and his daughter, aged six, were affected. He further remarks that if direct inheritance is doubtful, there can be no doubt of the influence exerted by a neurotic predisposition, inasmuch as the disease is frequently associated with hysteria, epilepsy, and mental diseases.

Marie related a case in a woman, aged fifty-two, who presented the following history:—

The mother died, at fifty-five, of "brain fever." She had maniacal attacks at each parturition. The father was blind at thirty-five. Five sisters and brothers died at early ages of undetermined affections. The patient herself had four children, all in good health. One girl had died of pulmonary phthisis, two other children of bronchopneumonia. She had had three miscarriages, and all her life had had articular rheumatism.

In a case recently under my care, the whole family was described as "very nervous"; an aunt of the patient had exophthalmic goître; a grandmother had a goître, which was supposed to be the same; the father was a "very nervous man," and died of apoplexy. The eldest daughter had exophthalmic goître. Seven sons died during infancy, from "water on the brain," and two girls have grown up healthy.

In a second case, of a lady, in whom the exophthalmic goître came on after parturition, the patient's sisters all suffer from migraine; one sister had a "fit" and facial paralysis; the father died of apoplexy; of four

[1] *Diseases of the Nervous System*, vol. i.

children only one is living. The first died of convulsions, living only two days after birth; the second and third children died of convulsions; the fourth boy died when twelve months old, from convulsions and "paralysis of the throat." The living child appears to be healthy.

Both these histories are remarkable.

In a third case under my care, occurring in a young girl of twenty-one, the father and mother were healthy, a brother and sister had frequent "fits" during early life, and a cousin has exophthalmic goître.

In a fourth case, two sisters of the same family had exophthalmic goître, and in a fifth case seen by me, the patient's younger sister was shortly afterwards brought to me for exophthalmic goître.

In another case, the father died of some cardiac affection; one brother had been paralysed since ten years old, and one sister was liable to fainting attacks. The patient's illness dated from an attack of diphtheria, which was followed by persistent palpitation, and in four months thyroid swelling appeared, exophthalmos being first noticed two months after this.

In another case, the mother died of jaundice; of three sisters and four brothers one brother had been insane, and was said to have been operated on successfully in London for "abscess of the brain," which was followed by recovery. One brother had jaundice a year before the patient came to me, and her illness dated from an attack of jaundice which was very soon followed by palpitation, and a little later by thyroid swelling.

Everyone knows how difficult it is to obtain from the majority of patients attending a hospital, anything like a proper history, and in some thirty cases I have been unable to learn anything of much value. The cases quoted are, however, sufficient to show how the disorder "runs in families"; and what part heredity plays in the development of the disorder.

There does not seem to be any close connection between common goître and Graves's disease. Thus, in places where the latter is common, *e.g.*, Ireland, the former is rare, and in those localities where ordinary goître is common, *e.g.*, Switzerland and some parts of England, Graves's disease is rare. Vetlesen has recently published some interesting etiological researches upon goître, based upon observations made upon 117 families living in the town of Hamar, in Norway, showing its hereditary relationships, and the frequency with which hemicrania is associated with it, having all the signs of a neurosis. Three patients out of the 117 families were said by him to be affected with Graves's disease. Thirteen cases of insanity and four cases of deaf-mutism occurred. It is possible that more than three of these patients may have had early signs of exophthalmic goître. While ordinary goître, through myxœdema and cretinism, owns some sort of apparent connection with Graves's disease through grave affections of the nervous system and by insanity, it is to be noted that the nervous and mental derangements are of a widely opposite nature. Thus, while deadening of the nervous faculties appears to be the rule in the former (abolition of nervous function, dementia, &c.), the whole progress of nervous symptoms in the latter is in the opposite direction, namely, towards exaltation or super-excitability, and the insanity is of a maniacal type.

There are cases midway between the two forms of goître, in which, along with a thyroid tumour, a few obscure nervous phenomena are present, which are, perhaps, but a slight departure from the normal. These it is sometimes difficult to interpret, to say whether they are going to develope into cases of Graves's disease, or whether they are merely ordinary goîtres with a slight degree of functional nervous disturbance. Perhaps a wider recognition of the importance and signs of incipient Graves's disease will diminish the number of these cases.

One must always bear in mind the close relationship that exists between Graves's disease and disorders of the nervous system, and I need only mention the occurrence of various nervous convulsive and spasmodic affections (*e.g.*, epilepsy, convulsions, chorea, tetany, &c.) and paralytic conditions (*e.g.*, motor paralyses, such as hemiplegias, paraplegias, &c.), to emphasize the point. This nervous relationship is not exhibited by ordinary goître.

Besides the individual predisposition, there is commonly an "exciting cause." This is sometimes to be found in painful emotions. Thus, Rendu[1] recorded a case of a lady, forty years old, whose son had compromised himself. The same evening she was taken with dyspnœa, violent thyroid throbbings, and cardiac palpitations, and passing the night on a couch in excessive agony, she developed all the signs of Graves's disease, except exophthalmos. She remained in a pitiable condition for many weeks. This patient for years had had excessive impressionability, had frequently had intense palpitation, and at the end of one pregnancy had been attacked with mania which lasted for fifteen days.

Moore,[2] of Dublin, recorded a remarkable case in which a young girl, on hearing of the death of a brother, instantaneously developed excessive rapidity of pulse (140), exophthalmos, and swelling of the thyroid gland. All the symptoms disappeared within forty-eight hours.

Roberts[3] recorded a case of acute bronchocele with cardiac hypertrophy which came on in a woman in the second week of pregnancy, the goître became larger, giving rise to great dyspnœa, delirium, cyanosis, and lastly asphyxia followed. Laryngotomy was performed, but the patient died of dyspnœa after the operation. The relation of goître to pregnancy will be discussed later on.

Mobius[4] related a case in which a woman of fifty, after painful moral emotions, was taken with tremors of the left hand like paralysis agitans, and soon after all the signs of Graves's disease followed.

Other cases of the same kind could be quoted, but would unnecessarily occupy space. I have often found that in persons with an unstable, impressionable, and excitable nervous system, the first signs of Graves's disease have been developed with rapidity after a long course of domestic trouble or worry. The functional nervous derangement is so marked, leading to excitability, unfitness for work, forgetfulness, irritability, and capriciousness, and the alteration of character is

[1] *Dict. Encyclop. des Sc. Med.*, 1881.
[2] *Dub. Journ. Med. Sciences.*
[3] *Amer. Journ.*, M.S., CXLIV., p. 374, October, 1876.
[4] *Betz. Memorab.*, Heft 3, 1883.

so real, that these unfortunate patients are frequently gravely misunderstood, both by their relatives and advisers, their mental aberrations lead to domestic troubles, and too exacting relatives treat them with severity, which, of course, only serves to intensify their unfortunate condition. They are called "hysterical," wilful, naughty; quarrels are the result, and legal separation betwen husbands and wives have even been the outcome.

In a person already predisposed to the advent of Graves's disease, with a neurotic history, and liability to attacks of functional nervous disorder, it probably needs but little as an exciting cause to develop even with extreme suddenness the full symptoms of exophthalmic goître.

Thus I have found the onset of the disease frequently attributed to hard and depressing work, pregnancy, disorders of the menstrual functions (though it is doubtful how much these are to be considered causative rather than part and parcel of the disorder itself), and even to tonsillitis. Most patients find a difficulty in attributing any cause for their complaint, and the general rule is a very gradual onset of symptoms.

Muscular effort has undoubtedly been the determining cause in some cases; thus, Whynne Foot described the case of a young man who danced all night. Two days after, febrile symptoms appeared, and the symptoms of exophthalmic goître rapidly followed. Mackenzie has seen it occur after forced marches, Walshe after a fatiguing mountain ascent, and Potain saw many cases after the Franco-German war, in Alsace-Lorraine. Most probably many of the cases occurring in the poorer classes of patients, artisans' wives, servant girls, &c., are to be attributed to a combination of hard daily muscular effort, with worry and anxiety.

Anæmia and chlorosis, so often met with, are probably less of determining causes than ordinary accompaniments of the disorder. Wilks long ago mentioned, speaking of early or undeveloped forms of Graves's disease, that he had seen many cases of this disorder, which had been treated simply for anæmia.

The condition of the blood in Graves's disease will be referred to further on.

Alteration of the catamenial functions is generally admitted to accompany Graves's disease. The most commonly observed is suppression of the menses. A great proportion of such patients, however, have no disturbance of this kind. It is not certain how much this alteration of function may be an etiological factor, or how much part of the general anæmic condition, consequently more or less of the nature of a coincidence. There is no doubt, however, that there is a close connection between fluxions of this gland and the genital organs. Thus, one often finds that exophthalmic goître commences with the advent of puberty, at the period of parturition or pregnancy, or at the climacteric, or if previously existent, is subject to great fluctuations of intensity at any of these great epochs, or even with the advent of normal menstruation. At such periods all the symptoms are much aggravated. Sloan, of Edinburgh, and de Soyre, have drawn attention recently to this well-known fact; and de Burine,[1]

[1] *Considérations sur le goître dependant de la grossesse, &c. Thèse*, Paris, December, 1886.

has insisted upon the sympathetic relation of the thyroid gland to the female genital organs, and imagines the thyroid gland at the periods of the catamenia or pregnancy, to become the seat of excessive vitality, consisting in the occurrence of increased vascularity, and formation of lymphoid follicles such as occur in all the female organs in the state of gravidity. The process is similar, probably, to the hypertrophy of the female breasts which has been noted in connection with Graves's disease, and which has occurred in patients who were otherwise emaciated.

Something has latterly been said about the *connection of throat complaints with exophthalmic goître.*

In a case lately recorded in the *New York Medical Record*, by Dr. Peterson, enormously enlarged tonsils were noted, and the writer dated their enlargement from the appearance of the thyroid tumour. He imagined a direct connection between these conditions, partly on account of the susceptibility of tonsils to vascular changes, partly because the tonsils are supplied direct from the dilated carotid system by means of the tonsillar artery. Dr. Peterson did not exclude the possibility of the tonsillar condition being of the nature of a coincidence. It is very difficult in such cases to determine the point as to whether there is any direct connection between the pharyngeal or tonsillar tissues and the general nervous condition of Graves's disease. I have looked through the notes of some thirty or forty cases which have been under my own observation, without being able to come to any conclusion. I find that one patient had had enlarged tonsils for a long period antecedent to the appearance of an enlarged thyroid; two complained of constant dryness of the throat, and the condition of the pharynx was such as to warrant the diagnosis of "dry pharyngitis." One of these cases was associated with simple polyuria. One patient had marked granular pharyngitis; three were subject to tonsillitis, and the condition came into close relationship with the thyroid enlargement; in one there were recurrent attacks of follicular tonsillitis at each menstrual period, with coincident enlargement of the thyroid; in a second, the thyroid enlargement and gradual supervention of symptoms of Graves's disease dated from an attack of quinsy; in a third, the thyroid tumour, which was previously gradually diminishing under treatment, experienced a sudden great increase in size, with the occurrence of a severe attack of tonsillitis. I do not think, however, that very much stress can be laid upon these facts, though they may, of course, be part of the general series of phenomena of vasomotor and nutritive disturbances. It is not unfrequent to find congestions of the naso-pharyngeal tract, attacks of follicular tonsillitis, &c., occurring along with physiological and pathological disturbances of the genital organs. There is, however, one throat symptom which is undoubtedly connected with Graves's disease in a very constant manner. This is *cough*. It is usually of dry, hard character, and is often spasmodic, and usually very distressing. It may or may not be associated with granular pharyngitis or dry pharyngitis; but with or without objective throat symptoms, cough is one of the most constant of the minor symptoms accompanying exophthalmic goître, and it has been particularly referred

to by Charcot and Marie. There is no, or very little, expectoration, or this, when present, is out of all proportion to the intensity of the cough. It occurs at any period of the day, or, in some patients, particularly in the evening or morning. Some patients complain that their cough entirely prevents sleep. There is nothing to be found in the lungs or bronchi to account for the cough, and it is undoubtedly a neurotic phenomenon, possibly dependent upon excessive excitability of the pharyngeal nerves, but also more probably upon hyperexcitability of the central nervous centres.

The nervous affinities of Graves's disease are the most interesting.

These are *sensory* or *motor neuroses*. The latter fall under the subdivision of the "spasmodic" or "paralytic." The *sensory affections* met with are hyperæsthesiæ, neuralgias, migraines and hemicrania, joint pains, and a spurious form of angina pectoris. There is, perhaps, nothing remarkable in these manifestations, but they serve to exhibit the general neurotic condition of the patient. Migraines and hemicraniæ are very often constant and distressing, and the pain is not unfrequently like the "clavus" of hysteria. Sometimes it is localised over the frontal region, at others is diffused over the head. Gros[1] has met with a case in which ophthalmic migraine was coincident with Menière's vertigo. I have often met with neuralgias of some branch of the trigeminal or the brachial plexus, or shooting pains in the arms or chest. The pains about the region of the heart suggest angina pectoris, but have nothing in common with it. Charcot has called it spurious angina pectoris. *Gastric crises*, not unlike those of locomotor ataxia, occur not unfrequently. In one of my cases these crises came on every day for a week, and would then leave the patient for a while only to recur. Perry and Kössner have also described visceral and gastric crises resembling tabes.

Epileptiform convulsions have frequently been noted, by Merklen[2] (chiefly of the right side), by Delasiauve[3] (crises occurring at first ten times a month, and the epileptic state preceded the development of Graves's disease by a long period), by Ballet[4] (in which the epileptic state followed the development of Graves's disease by four months), by Cardarelli[5] (in a woman, hystero-epileptic, and in whom exophthalmic goître with vitiligo and alopecia followed), and by Panas[6] (in which the epileptic attacks preceded the development of Graves's disease by a long period). A history of epileptiform convulsions is often obtained in the other members of a family of a patient with Graves's disease.

Muscular atrophies have been noted in the hand muscles in a curious case mentioned by Cardarelli, of exophthalmic goître in a boy of twelve years old, in whom were present "apoplectic" convulsions, left hemiplegia and pseudo-hypertrophic paralysis; also by Silva,[7] in which it affected

[1] *Thèse.* Paris, 1884.
[2] *Société Clinique*, February 24, 1882.
[3] *Soc. Méd. des Hôp.*, November 27, 1874.
[4] *Mal. nervose e funzionali del cuore.* Naples, 1884.
[5] *Archiv. d'Ophthalmologie*, February, 1881.
[6] *Goitre Exophthalmique, &c. Arch. d'Ophthalmologie*, Fev. 1881.
[7] *Sul morbo di Basedow. Gaz. delle Clin.* ii., 16-18, 1885.

the interossei, and in the remarkable case recorded by Féréol,[1] in which the atrophy commenced in the two right limbs, affecting them *en masse* and not localized in special muscles. This was combined with marked hyperalgesia of the whole right side, and diminution of thermic sensation and pronounced reflex excitability of both sides, but especially the right.

Atrophy must not, however, be confused with general muscular wasting of a limb, such as occurs in hemiparesis, or from disuse, as is frequent in these cases.

Cazal (*Gaz. Hebdom.* May 22, 1885) recorded a case in which there was skeleton-like thinness of all the face, all the muscles being atrophied, the thinness of the lips and cheeks making the teeth appear long and prominent. The atrophy was not confined to the face, not a single group of muscles in the body having appeared to escape. Those of the back, thorax, upper and lower limbs had all disappeared. To stand was impossible, and such attempts were accompanied by convulsive tremor of the whole body. All the symptoms amended under antipyrin.

In the case recorded by Dreyfus-Brissac (*Gaz. Hebdom.*, 1885) there was paresis of the right arm, with tremor and tetany. The right forearm was atrophied, the thenar and hypothenar eminences and the interossei of the right side. Sensation was diminished in the region supplied by the ulnar nerve; these muscles responded badly to the galvanic current.

Convulsions have been noted by Brunton,[2] by myself, and by others.

Chorea was noted in a case published by Gagnon,[3] whose patient, a young girl of twelve, had all the signs of exophthalmic goître, and a year later developed chorea; and Jacobi[4] published an interesting case of chorea following upon exophthalmic goître in an infant. Gueneau de Mussy[5] has also referred to the connection of chorea with Graves's disease.

Tetany was observed in a case recorded by Dreyfus-Brissac.[6]

Cramps have been recorded by Chvostek,[7] as occurring in the muscles of the neck and shoulder, alternating with cramps of the muscles of the calves.

Ataxia was described by Féréol[8] in a remarkable case, in which the patient was propelled towards the right and suffered diminution of sensibility of this side; diplopia in certain positions of the eyes; violent cephalalgia, vertigo, sensations of heat and cold distributed unequally over the cutaneous surfaces, and commencing atrophy of certain muscles of the right side, along with the ordinary symptoms of Graves's disease.

The *sensation of dead fingers* is sometimes met with. In one of my cases this was accompanied with prickings and tinglings of the tips of the fingers of the left hand, and the patient, after picking a pin from the

[1] *Soc. Méd. des Hop.*, November, 1874.
[2] *St. Bartholomew's Hospital Reports*, 1874.
[3] *Assoc. franc. pour l'avancement des Sciences*, 1876.
[4] *New York Medical Record*, 1879.
[5] *Clinique Méd.*, t. iv.
[6] *Gaz. Hebdom.*, 1885.
[7] *Wien. Med. Presse*, 1876.
[8] *Loc. cit.*

table, felt she did not know that she had it in the fingers. This condition is not unlike that met with in peripheral neuritis. The sensation may come on and last for a quarter or half an hour, and may affect one or both sides, occurring very frequently, as in a case reported by Sainte Marie.[1] In one of the latter author's cases local syncope and phenomena analogous to Raynaud's disease were met with.

Falling of the eyebrows and eyelashes have been noted by Burney Yeo[2] and Rendu; and *alopecia* by Cardarelli. These are only evidences of the widespread interference with nutrition accompanying the disorder, and I have seen the same thing in Graves's disease.

Mental disorders and disturbances are frequent in Graves's disease. All physicians are aware of the remarkable change which comes over the character of a young female afflicted with this complaint. Peevishness, irritability, inapitude for work of any kind, capriciousness, morbid self-introspection and suspicion, violent fits of anger almost without provocation, terror and frights, maniacal attacks, sometimes with suicidal tendency, insomnia, nightmares, forgetfulness, loss of memory, and mental confusion, all demonstrate the profound alterations of the central nervous system and higher cerebral centres of these patients. Dr. Savage has shown how these cases sometimes end in insanity, and has recorded cases which have come under his observation.

Robertson[3] related a case of Graves's disease in a man, who became greatly suspicious of every one around him. Becoming violent, he was sent to an asylum. On the evening of admission he had an epileptic fit (never having had one before or after), and chemosis of the right eye. Sloughing of the cornea followed.

Patients with Graves's disease are especially liable to be profoundly altered mentally at the catamenial periods. At such times they become violently excitable, and say and do things which indicate mental aberration. In the intervals between the periods they will, however, be rational. This mental disturbance, at first manifested in little more than alteration of character, peevishness, capriciousness, inaptitude for work, want of application, &c., may precede the onset of Graves's disease for a considerable period, or until a slight cause (fright, anger, passion, &c.) may determine the attack. This psychological alteration should always be looked for in any suspected case of Graves's disease. It is constant, and may lead to the true recognition of the case, when there might otherwise be doubt, in the absence of the more prominent signs of the disease.

Insomnia is a very constant accompaniment of Graves's disease. Though this is sometimes referred to excessive palpitation, to sweating, or the abnormal sensation of dry heat, it oftener has no apparent objective cause. Bad dreams, nightmares, and somnambulism, are found associated with it in a number of cases. One finds some cases, curiously enough, in which insomnia is not a prominent symptom.

Secretory disturbances in Graves's disease are common. Sweating, general or local, is a constant accompaniment of the condition. Some-

[1] *Thèse.* Paris, 1887.
[2] *Brit. Med. Journal*, 1887.
[3] *Journal of Mental Science*, 1875, vol. xx.

times it occurs over the whole body; at other times it is of the head, chest, back, &c., only. It is rarely unilateral, but Chvostek and Ebstein noted such a case, affecting one side of the face, in which there was also retraction of the pupil of the corresponding side.

Such local sweats are sometimes observed in regions which are anæsthetic, *e.g.*, the parts supplied by the ulnar nerve. Other patients do not sweat much, but complain greatly of a sensation of dry burning heat.

Glycosuria and *albuminuria* have been met with, as is well known, but these are not common accompaniments of the disorder. *Polyuria*, however, is frequently met with. *Disturbances of temperature* are general. Though I have seen it stated that in Graves's disease the temperature is not raised at all, careful observations upon this point made upon my cases by my former clinical assistant, Dr. Cecil Shaw, have proved that in nearly every case under observation the temperature is constantly one degree, or a little more, above normal. Charcot also states the same observation, and I have no doubt that it is a nearly constant phenomenon.

(*To be continued.*)

NEW INSTRUMENTS AND THERAPEUTICS.

BROICH (Hanover).—**A Simple Nasal Cleanser, and its Therapeutical Use.** *Berlin. Med. Woch.*, No. 28, 1888.

THE instrument is a glass balloon, which is used by the author in place of the nasal douche. **Michael.**

CHOLEWA (Berlin).—**A New Nasal Speculum.** *Deutsch. Med. Woch.*, No. 30, 1888.

THIS is a modification of Kramer's ear speculum. **Michael.**

KRIEG (Stuttgart).—**I. A Simple Electrical Lamp. II. Application of Thermocautery to the Nose in place of Galvanocautery.** *Wurtemb. Med. Corresp.*, No. 20, 1888.

THE first is merely a petroleum lamp.

In the second communication the author states that thermocautery can be used with good effect to the nose and naso-pharynx. **Michael.**

SCHEFF.—The Rotating Sharp Laryngeal Spoon. *Wiener Med. Woch.*, No. 24, 1888.

IN the case of sessile neoplasms the author uses a sharp spoon, which can be set in rotation by a special mechanism. **Michael.**

BROCKMANN (Kalisz).—**The Tube Forceps of Gottstein.** *Monats. f. Ohrenh.*, No. 6, 1888.

THIS instrument cannot be used in cases in which force is required, since it can break easily. The author has seen it do this in one case.

Michael.

D'HEILLY.—The Treatment of Whooping-Cough. *Rev. Gén. de Chir. et de Thérapeutiques*, May 24 and 31, 1888.

A REVIEW of the different methods of treating whooping-cough. The author states that he has had good results from nasal insufflations, as employed by Michael and Moigard. **Joal.**

DUBOUSQUET-LABORDERIE.—Whooping-Cough and Antipyrine. *Bulletin Thérapeutique*, June 15, 1888.

THE author had used antipyrine in fifteen cases of whooping-cough: and eleven times has obtained complete cure in twelve to sixteen days. The dose employed has been 30 centigrammes to 1 gramme for children up to two years of age, and 1 to 4 grammes for older children and adults. **Joal.**

SCHNITZLER (Vienna).—**The Therapeutical Action of Kreolin in Diseases of the Mouth, Nasopharynx, and Larynx.**

THE author has made trial of inhalations, gargles, and brush applications of this new antiseptic in diphtheria, angina follicularis, and tubercular and catarrhal affections of the upper respiratory tracts. The effect was satisfactory. He also administered it internally in cases of tuberculosis. Small doses must be used at the commencement, as the drug cannot be tolerated by all individuals. **Michael.**

WENDT, E. C. (New York).—**Recent Views regarding the Pathology of Pertussis.** *Med. News*, June 2, 1888.

WENDT closes a carefully prepared paper on the subject as follows:—

(1) There is constantly associated with whooping-cough a special micro-organism discovered by Afanasieff.

(2) This microbe is a small bacillus, having properties that distinguish it from all other known bacteria.

(3) The "bacillus pertussis" (*bacillus tussis convulsivæ*, Afanasieff) can be readily demonstrated in the sputum of patients having the disease.

(4) While its etiological significance appears established, it does not possess much diagnostic importance, since it is found only after the clinical features of the disease are already well marked.

(5) The treatment of pertussis has not yet been materially advanced by this discovery.

(6) Antiseptics locally applied do not appear to shorten the duration of the disease.

(7) Hygiene and judicious alimentation are, in the present state of our knowledge, of at least equal importance with medicinal treatment.

(8) Antipyrin and the bromides are reliable symptomatic drugs, and are devoid of danger.

(9) A specific has not yet been found.

(10) Abortive forms of pertussis may occur, but no plan of treatment now known can claim to have abortive efficacy. **J. N. Mackenzie.**

WIDOWRITZ (Graz).—**Treatment of Whooping-Cough.** *Wien. Med. Wochenschr.*, 1888, *No.* 17.

RECOMMENDATION of internal use of oxymel of squills. **Michael.**

GRANCHER.—Action of the Vapours of Hydro-Fluoric Acid on the Tubercle Bacillus. *Soc. de Biologie*, June 2, 1888.

GRANCHER has made a series of experiments, which prove that the action of hydro-fluoric acid on the evolution of experimental tuberculosis is completely null. He does not think that one can legitimately hope to attack and destroy the tubercle bacillus by these vapours. Nevertheless, as they are well supported by patients, and they diminish the vitality of the bacillus, they may be employed for pulmonary phthisis.

Joal.

DIPHTHERIA.

BARNES, E. G.—An Address on the Etiology of Diphtheria. *Brit. Med. Journ.*, July 28, 1888.

THE observations contain results of investigations into 50 separate outbreaks of diphtheria, extending over 13 years, embracing 223 cases and 40 fatalities.

The author thinks that diphtheria may arise from certain combinations of filth and insanitary conditions, independently of pre-existing cases of diphtheria.

The favourite habitats of diphtheria are shown by the author, by carefully-drawn maps, to be different from those of scarlet fever. The former is most prevalent in thinly-populated districts in the south-eastern and eastern counties of England, in Cornwall, Somerset, and North Wales, avoiding the populous manufacturing and mining centres, and the northern counties of England. Scarlet fever, on the contrary, affects the more populous neighbourhoods. The author thinks that this localization of diphtheria in rural districts is due to dampness of soil, caused by want of suitable drainage, along with filth in the form of decomposing animal matter. Certain parishes, and even certain houses, are liable to recurrent attacks of diphtheria, and this is possibly due to a recurrence of the conditions under which the disease is generated. The nature of the soil may or may not have some causal connection with outbreaks. One great agent in the spread of the disease is school attendance. Diphtheria shows an annual exacerbation during the winter months. In outbreaks of diphtheria it is common to find that sore throats have prevailed for some time previously, which have not presented the characters of diphtheria. **Norris Wolfenden.**

BARBIER H.—Albuminuria in Diphtheria. *Gaz. des Hôp.*, May 12, 1888.

AN excellent bibliographic review of the subject. **Joal.**

BROUARDEL and DU MESNIL.—Epidemics of Diphtheria. *Bull. Médicale*, June 6, 1888.

STATISTICS of mortality resulting from diphtheria in France during 1886. Reports incomplete, only being furnished by 210 towns **Joal.**

FERÉOL.—Insidious Diphtheria of an Unusual Kind. *Soc. Méd. des Hôp.*, May 19.

THE case of a woman, aged fifty, who died in four days from diphtheria. The disease, which on the first day was situated in the throat, spread rapidly to the respiratory organs, and was localized successively in the larynx, trachea, and bronchi. The lungs escaped, since tubular breathing was not observed. It is probable that the large quantity of sugar found in the urine influenced to a considerable extent the fatal termination of the disease. **Joal.**

ORY.—Treatment of Diphtheritic Angina by Local and Frequent Applications of a Concentrated Solution of Salicylic Acid. *Soc. Méd. Pratique*, June 11, 1888.

THE author uses the following solution :—

Infusion of Eucalyptus, 100 grms.
Glycerine, 100 grms.
Salicylic Acid, 0.30 grms.
Cherry laurel water, 1 grm.

The pharynx is touched with this, every hour during the day, and every two or three hours during the night, with a large pencil. Ory has employed this method for seven years, and has never been obliged to perform tracheotomy. **Joal.**

NOSE AND NASO-PHARYNX.

GRAHN (Wurzburg).—**Dacryocystoblennorrhœa and Diseases of the Nose.** *Munchener Med. Wochens.*, No. 27, 1888.

THE author has seen a combination of these two conditions in thirty-four cases, and believes that the former condition is produced by propagation and infection. **Michael.**

ROBERTSON, W. (Newcastle).—**A Plea for the Use of the Rhinoscope.** *Lancet*, August 18, 1888.

ONE case in which extensive ulceration was diagnosed with the mirror, round the right nares posteriorly, and the naso-pharynx was blocked with crusts. Patient had had a chancre four years previously, and was deaf. He was cured by chromic acid (locally), mercury, and iodide of potash.

The second case was that of a woman with a polypus protruding from the posterior extremity of the right nares, and a second one more anteriorly. Severe pain in the nape of the neck, periodical attacks of somnolence in the daytime, palpitation, depression, and irritability of temper had lasted ten or eleven years. With removal of the polypi all symptoms disappeared. **R. Norris Wolfenden.**

VON KLEIN, CARL H. (Dayton, Ohio).—**New and Illustrative Points in Examination of the Nose and Throat.** *Phila. Record :* McMullin & Co., 1888, pp. 7.

DR. VON KLEIN finds it "necessary to have different-shaped tongue-

depressors for every patient'; for, as he says, "the merit of the patient handling his own tongue-depressor is too obvious, and needs no reinstatement." For a "concaved" tongue, any depressor may be used; but when the tongue is "convexed," one similar to a Sims' uterine speculum is employed, which is bent by the operator to suit the requirements of individual cases. The advantages claimed are, that the convex bottom acts as a depressor, the upper edges support the roof of the mouth, and make the tongue "irresistible," while the concave portion makes a "scopic channel" to the throat.

The nose "has become the victim of different inventions of speculums," all of which are "torturing apparatuses," and our author, in order to overcome all this, has devised a two-bladed speculum with very long handles, which is introduced and held by the patient; and which, to judge from the placid features of the young man in the accompanying woodcut, is doubtless an excellent instrument. **John N. Mack**

HOPMAN (Cologne). — **On Congenital Stenosis of the Nose.** *Langenbeck's Archiv.*, Band 37, Heft 2.

A COMMUNICATION upon fourteen cases collected from literature, with two original cases of the author's.

1. A very scrofulous patient, eleven years of age, and breathing only with the mouth, had excessive secretion of pus from the right nares, with closure of this passage. On digital examination, an osseous wall was found to close the right nares. Under narcosis, this osseous septum was broken by means of mallet and elevator. The new opening was kept patent by drainage tubes for a year, and the child eventually cured.

2. A patient, nineteen years of age, had complete congenital closure of the right choanæ, and the posterior part of the right nasal fossa. An operation was performed similar to the other case. Six weeks later the patient was cured. **Michael.**

MOUTH, TONSILS, PHARYNX, &c.

MADELUNG (Rostock).—**Two Rare Malformations of the Face.** *Langenbeck's Archiv.*, Band 37, Heft 2.

1. A CHILD, twenty-four weeks old, had cleft palate and two fistulæ of the lower lip. Such cases are very rare.

2. A case of congenital nasal defect of the right side, operated upon in the case of a patient twenty years of age. **Michael.**

MILLER (Berlin).—**The Recognition of the Micro-organisms of the Mouth.** *Deutsch. Med. Woch.*, No. 30, 1888.

THE author has found:—(*a*) leptothrix buccalis; (*b*) leptothrix maxima buccalis; (*c*) bacillus maximus buccalis; and two new forms which he calls iodococcus magnus and parvus. In pathological cases, staphylococcus also occurs. **Michael.**

EVE, FREDERICK.—**Actinomycosis.** *Practitioner*, May, 1888.

A PAPER based on specimens in the Museum of the Royal College of

Surgeons. Moosbrugger's statistics regarding the distribution of the disease in man are given. Of seventy-five cases, the disease in twenty-nine was in the neighbourhood of the lower jaw, in the mouth and neck; in nine in the upper jaw and cheek; in one case in the tongue, and in two involving the pharynx and œsophagus; eleven in the intestines and abdominal viscera; fourteen in the bronchial tubes or lung. In seven cases the seat of the disease could not be ascertained. The frequency of the primary disease in or near the mouth and jaws may be gathered from the fact that in forty out of seventy-five cases it affected those parts. Up to the present time only four cases have been observed in the tongue in man, whereas lingual actinomycosis is not uncommon in cattle.

It is worthy of remark that while over seventy cases have been recorded on the Continent only seven had been published up to 1887 in England and America. This may be explained either by supposing that this disease often passes unrecognized in England or America; or that it is more common on the Continent. Should the latter surmise prove correct, the Teutonic fondness for sausages and uncooked ham may explain the diversity, especially from the fact that pork is affected as well as beef. When flesh is prepared in the usual way the morbid change is so evident that its transmission to man by diseased meat is improbable. Direct inoculation of man from animals occurs rarely. In only ten of the seventy-five cases mentioned were the individuals engaged in occupations which brought them into contact with cattle, and in two only had the sufferers to do directly with diseased cattle. In one of these, a case of actinomycosis of the tongue, the patient had opened and subsequently looked after a tumour of the jaw in a cow. **Maxwell Ross.**

LOGAN, J. R. (Liverpool).—**Leucoma of the Tongue.** *The Liverpool Med.-Chir. Journ.*, July, 1888.

THE case of a man, aged fifty, addicted to alcohol, syphilitic, and a heavy smoker. Four to six years ago there were occasional ulcers on the right border of the tongue, the site of which is now represented by a depressed cicatrix, and this is continuous with the leucomatous patch which covers the greater part of the dorsum, which is irregular in outline, opaque white, not elevated, smooth, moist, and not differing in resistance to the finger from other parts. General health is excellent.

Antisyphilitic treatment, boracic acid, and bicyanide of mercury have been of no effect. The author considers the prognosis grave, since carcinoma not unfrequently develops in such cases.

R. Norris Wolfenden.

HOBBS, A. G. (Atalanta).—**The Nervous Phenomena observed in a Case of Exposure of the Anterior Column of the Cord, from Syphilitic Ulceration of the Upper Pharynx.** *St. Louis Med. and Surg. Journal*, November, 1887.

YOUNG man, healthy, weighing 140 pounds. A posterior rhinoscopic examination revealed an ugly sloughing ulcer in the posterior and superior wall of the pharynx about the size of a 25-cent piece. The probe discovered dead bone at the depth of about $\frac{1}{2}$ inch. At each visit small pieces came away in cleansing the ulcer. The treatment was

based upon the assumption that the ulcer was syphilitic, notwithstanding assurances that he had been healthy from infancy, and had never had any venereal disease. He was placed on iodide of potash, 40 grs., three times a day in a menstruum of succus alterans. The ulcer was thoroughly disinfected, and nitrate of silver applied with a cotton carrier, after which the cavity was packed with iodol. About this time, after four or five weeks of daily treatment, the symptoms first appeared.

"For a week or ten days he had been complaining of constant pain in the back of his head and neck, which caused him to carry his head to one side and rigidly. During this period—the four or five weeks—he had been unable to sleep except for a few minutes at a time and in a sitting posture. After the cavity had been thoroughly cleansed at one of the treatments I pressed the nitrate of silver probe to its bottom, when, as suddenly as if he had been shot, one half of the patient's body became paralysed—his head fell to the right, his right arm dropped to his side, his right leg turned outward, and he would have fallen from the chair if I had not caught him. Without losing consciousness at any time, this hemiplegic condition lasted about thirty seconds, when, as he expressed it, 'he felt a tingling in the right half of his body,' and in another half minute he slowly raised his right side into position. The next day the same phenomenon was repeated, *but on the opposite side*.

"He was now so reduced in weight and strength by the loss of sleep and constant pain that he could not walk to my office. The extreme insomnia lasted about ten days, during which time his attendants thought he did not sleep one hour in twenty-four.

"The pupil of the eye on the corresponding side of the paralysis was very slightly dilated.

"The perspiratory glands were not perceptibly altered in any way on either side of the body during the hemiplegic attacks. But from this time healing began at the bottom of the ulcer, the discharge became less, and examinations with the finger did not discover any more rough bone; he slept better, and did not complain so much of the pain in the back of his neck.

"He naturally did not desire that a paralysis should be deliberately produced now, because he was not certain, nor could I with much confidence assure him that it would only last one minute if repeated.

"A week passed on with all his symptoms gradually improving, when I could no longer resist the temptation of making another pressure with the probe. Paralysis of the side pressed upon followed each pressure of the probe, but in a much milder degree than before, ending in the same tingling sensation, as described before. As only the spray and powder-blower were used from this time onward in dressing the cavity, no more pressures with the probe were made till healing had well progressed probably ten days or two weeks after the last test.

"To my surprise, when the probe was now pressed into the cavity a condition just the opposite of paralysis was exhibited:—the arm and leg jerked and jumped similar to a case of chorea. These choreic muscular contractions, unlike the paralysis, lasted only during the pressure of the probe. In repeating the probe pressure at intervals during the next few

days the same choreic symptoms were produced, always on the corresponding side of the pressure, but in a less and less degree, requiring a still firmer pressure to produce the effect.

"Finally, when the healing process had been thoroughly established and cicatricial tissue had in a measure closed up the cavity, only a 'tingling or prickling' sensation followed the probe pressure—a sensation similar to that which followed the hemiplegia in the first instance. After the cicatricial tissue had thoroughly hardened no manifestation followed the pressure of the probe.

"At the present writing, ten months since I first saw the patient, he has entirely recovered and presents a picture of perfect health, weighing 135 pounds, 37 to 40 pounds more than he weighed in November of last year. He was kept on a lessened dose of iodide of potash and succus alterans until last July.

"I cannot state accurately as to the total amount of dead bone taken from the cavity, but I should say that its area would about equal that of a medium sized almond.

"The sequel, it would seem, proved my diagnosis to be correct. Since the ulcer had gradually increased in size for six months prior to the beginning of the anti-syphilitic treatment, and though he did not improve at once, as soon as the local treatment succeeded in cleansing the ulcer of necrosed bone, healing began and the more serious symptoms became less.

"The case is of even greater interest to the neurologist than to the rhinologist, and had more systematic experiments been made, and closer examination been taken of the nervous phenomena, something of greater interest might have been gained."

The author thinks the necrosis occurred in the anterior process of the second cervical vertebra, and the spinal cord, therefore, must have been exposed between the second and third vertebræ. The probe pressure always produced its effect on the corresponding side of the body. The pressure that produced the paralysis must have injured the anterior column by pressing a jagged piece of bone against the cord, and the pressure that produced the convulsions must have only irritated the anterior columns, since it is well known that irritation of the anterior column produces immediate convulsions, and a wound produces immediate paralysis.

John N. Mackenzie.

INGALLS, FLETCHER.—Case of Retro-pharyngeal Abscess, followed by Deep Fistulous Tract. *Journal of American Med. Assoc.*

THE patient, a woman aged forty-four, was seen for first time in August. She complained of oppression, purulent discharge from pharynx, with pain between shoulders, cough, and night-sweats. Every few days a discharge of pus would occur, which relieved cough and other annoying symptoms for some time, when they would again appear, increasing steadily until another evacuation of pus occurred. Six months before, she had suffered from retro-pharyngeal abscess, which had been allowed to take its course for two months, when an opening was made at lower part of pharynx, and a quantity of offensive pus discharged. The patient

had purulent discharge from right ear while swelling was still in pharynx. Examining chest, slight feebleness of respiratory sounds was found over lower third of right lung. At lower third of pharynx a fungoid mass was seen, and removed with snare; beneath it was an opening about two millimetres in diameter. A small elastic catheter was passed in it, and gently pushed down fistulous tract a distance of thirty centimetres; pain was complained of at its extremity, a little to right of and below right breast. Dr. Ingalls was under the impression that when the lower part of sac was filled with pus it might be possible to detect it, and make a counter-opening through the pleural sac, whereby constant drainage could be established, and healing effected. **T. Morris Murray (J.N.M.)**

BLOCH (Freiburg).—**On the Bursa Pharyngea.** *Berlin Klin. Wochenschr.*, 1888, *No.* 14.

A GOOD report on the publications concerning these diseases, with some original observations. **Michael.**

LARYNX.

GOUGENHEIM AND PERRIER.—Cyst of the Sub-hyoid Region; Deviation of the Larynx; Disturbances of Voice and Respiration. *Ann. des Mal., &c., February*, 1888.

THE cyst was firm, elastic, situated in the right sub-hyoid region adherent to the larynx during deglutition. The larynx was deviated to the left and its interior inaccessible to view; an exploratory puncture revealed the cystic nature of the swelling. A second puncture brought away thick liquid containing a large amount of cholesterin. Tracheotomy was done on account of increasing suffocative attacks. Deep adherences prevented the complete dissection of the cyst; it was partially dissected off, and its walls touched with chloride of zinc (one in ten).

It completely disappeared, and the larynx and voice became normal.

R. Norris Wolfenden.

DESVERNINE, C. M. (Havana).—**A Contribution to the Normal and Pathological Anatomy of the Vocal Bands.** *Crónica Médico-Quirúrgica, and rewritten in English by the Author.* Havana: Soter, Alvarez, & Co., 1888.

THE first part of this essay is occupied by a study of cystic growths. From 156 cases tabulated by the author he concludes that intra-laryngeal cystic tumours occur with greatest frequency upon the vocal bands. No case on record has permitted the study of these new formations in undisturbed relation with the surrounding parts. A case has occurred in Dr. Desvernine's practice which has enabled him to fill this gap. In this case of cysto-fibroma "with rich epithelial investment with un-

deniable Malphigian characters," the pathological factor must be localized "in such elements of the vocal band which have an ectodermic embryological origin, namely—the dermo-papillary mucosa, the racemose glands, or the excretory ducts." The author locates this process in the glandular epithelium, which has progressed to the para-glandular connective tissue, has condensed it layer by layer, with the peri-glandular elements, "to form a highly-fused fibrous whole."

The author next studies "the glandular apparatus of the vocal bands" in great detail; and in contradiction of the statements of Luschka, Morell Mackenzie, Gottstein, Lennox Browne, states that the vocal bands indubitably possess a glandular apparatus constant in its presence and perfectly well developed. The priority of having demonstrated this fact belongs to Coyne. The vocal bands are defined by the author to be "the whole ligamentous system constituted by the horizontal thyro-aryteno-cricoid fasciculi, and by the ascending crico-thyro-arytenoid fibres." The mucosa of these bands therefore extends inferiorly with the band to the upper border of the cricoid in the whole ascent of the cricoidal ascending fibres. All the glands embedded in this region must be considered constituent elements of the glandular apparatus of the vocal bands. The mucosa lining the vocal ligaments may be divided into three segments. 1. The ventricular, or superior portion. 2. The glottic portion. 3. The infra-glottic portion. The first and third portions alone are supplied with glands. The glands of the superior surface form a group, deeply seated near the thyro-arytenoid fibres towards their ventricular border. Their excretory ducts are directed obliquely upwards and towards the glottic border and terminate on the superior surface. Their position is variable. They may be very deeply seated, in, or subjacent to, the thyro-arytenoid muscle, and they are then absent from the submucous connective tissue. Their number never exceeds three or four. The subglottic region is plentifully supplied with glands. They are always here embedded in fibro-elastic structures. Their excretory ducts are directed obliquely upwards and inwards. The author finally considers the pathology of cystic growths in the light of his histological researches. He concludes, "The excretory ducts traverse, *very frequently*, in the supra-glottic region, and *constantly* in the infra-glottic zone, fibro-elastic structures in a frequent state of energetic distension, and consequently must be compressed violently—while the structures of the bands are in complete physiological integrity, the obliteration is always transitory, momentary, but as soon as congestive or inflammatory derangements occur, of some duration and intensity, then the excretory ducts participate in the general process of hypernutrition, their walls become more or less thick, their elasticity is reduced or abolished, and their situation in the midst of structures actively compressing them, are all circumstances which create the best adapted conditions to promote the permanent fusion of their walls."

The author's paper is one of great interest, and is illustrated by three beautifully-executed coloured plates. His histo-pathological contributions, of which others are promised, are of the greatest importance. The paper should be read in the original.

R. Norris Wolfenden.

GOTTSTEIN. — **Local Treatment of Laryngeal Tuberculosis.** *Breslauer Aerzte. Zeitsch.*, No. 13, 1888.

A REVIEW upon the methods of treatment now in practice. **Michael.**

MIDDLEMASS-HUNT, J. (Liverpool). — **Local Treatment of Laryngeal Phthisis.** *The Liverpool Medico-Chirurgical Journal*, July, 1888.

THE author thinks that tubercular laryngitis may be primary, and quotes Demme, Orth, Fränkel, and Pogrebinski, each of whom has recorded cases in which the lungs were entirely free from complication. For the treatment of the first stage of anæmia, he advises stimulating inhalations (pine oil and creosote), and brush applications of iron or zinc chloride. He strongly objects to the use of nitrate of silver. The simple catarrh which often occurs in pulmonary phthisis is to be treated by sedative and moderately stimulating inhalations and mineral astringents—especially perchloride of iron, or sprays of bichloride of mercury (1—2000). Eucalyptus oil is especially valuable in relieving the cough of early laryngeal phthisis.

The author passes under review the drugs now much used, viz., iodoform, lactic acid, iodol, and menthol. He prefers iodol to iodoform, as a local insufflation, and confirms the observations of Lublinski and Wolfenden as to its power to heal ulcerations and relieve symptoms. The author does not think that lactic acid is suitable for all cases, as in some it gives rise to severe pain and inflammation; and it should not be used in advanced stages, or in cases with narrowing of the glottis from œdema or new formations, especially as it is liable to produce spasm. He has not obtained the favourable results recorded by Heryng, but thinks, nevertheless, that it is the best drug we at present possess for the treatment of this disease. The author does not recommend the adoption of Moritz Schmidt's method of making deep incisions into the laryngeal tissues, and thinks the practice introduced by Heryng, of curetteing before applying the lactic acid, is extremely severe, and should require very favourable results before being adopted here. He does not think that tracheotomy in laryngeal phthisis can do otherwise than as Morell Mackenzie suggests, viz., keep up irritation in the larynx, instead of favouring rest to the organ, but quotes Hunter Mackenzie, who recorded a case in which lupous ulceration of the larynx ceased to progress after tracheotomy. **R. Norris Wolfenden.**

HERYNG, TH.—**The Curability of Phthisis of the Larynx and its Surgical Treatment.** *Paris, Carré*, 1888.

A FRENCH translation by Dr. Schiffers of Heryng's excellent work. The translator is to be complimented as well as the author. **Joal.**

HENNIG (Konigsberg).—**Tubercular Tumours of the Larynx; Laryngotomy.** *Berlin. Klin. Woch.*, No. 28, 1888.

THE author performed laryngotomy upon a patient of fifty-three (who for some time had had bronchitis and gastritis), for two large tumours of the

larynx, of hard consistence and globular form, and possessing a broad base. The patient died 14 days later. At the autopsy, chronic tuberculosis was found in the lungs, and microscopical examination of the tumours showed them to contain many large tubercles, and tubercle bacilli. As cases of tubercular tumour are very rare, this fresh case is of great interest. Michael.

LEWIS, BRANSFORD (St. Louis).—**Tracheotomy in Morphine Poisoning.** *Journal of the Am. Med. Assoc.*, May 19, 1888.

DETAILED account of a desperate case of morphia narcosis, in which the trachea was opened and respiration kept up by a bellows such as that used in the physiological laboratory in the performance of artificial respiration in dogs. This operation was first done by Dr. G. E. Fell (*Buffalo Med. and Surg. Journal*, Nov., 1887.) Since this, Fell has done the operation successfully in two other cases. The method has been subsequently employed in Vienna.

Dr. Lewis believes that, in view of the results in this hospital case, in morphine poisoning, when other means fail, though no bellows respiration be possible, tracheotomy is a wise and justifiable measure.

John N. Mackenzie.

SCHNEIDER. — **On Granulation Stenosis after Tracheotomy.** *Breslauer Aerzst. Zeitsch.*, Nos. 9, 10, 11, 12, 13, 1888.

A VERY complete report upon this condition, with one new case. A full report was made some months ago of the paper of Köhl upon the same subject. Michael.

AHRONSON (Berlin, Ems).—**The Pathology of Dilatation of the Glottis.** *Deutsch. Med. Woch.*, Nos. 26, 27, 28, 1888.

THE author has discovered the interesting fact, that in all cases in which the cause of paralysis of the posticus muscles is found in an affection of the nerves in relation, there is also a tachycardia, and increased frequency of pulse. It may, therefore, be stated, that if there is no increased frequency of pulse, some organic disease behind the ramification of the recurrent nerves, myopathic paralysis of the postici muscles, or contraction of the adductors, must account for the condition. In six cases of central disease he has found a pulse rate of 100-120. He then gives an exact description of fourteen cases, particulars of which must be looked for in the original. Michael.

JELENFFY (Buda Pesth).—**On the Electric Contractility of the Laryngeal Muscles after Death, and Etherisation.** *Berlin. Klin. Woch.*, No. 26, 1888.

FROM experiments made by the author and Prof. Regescy, the following conclusions are arrived at :—

1. From electrical irritation of a nerve which sends fibres to extensors or flexors, both sets of muscles contract at the same time.

2. If the nervous system is not interfered with, the flexors preponderate.

3. During narcosis, the electrical excitability of the flexors decreases in inverse proportion to the degree of narcosis.

4. The crico-arytenoid muscles are extensors, the muscles closing the glottis are flexors.

5. The extensors possess a greater resistance to the effects of ether and chloroform than the flexors. **Michael.**

SAVILL, T. D.—Hysterical Aphonia in a Woman aged Seventy-one—Recovery—Remarks. *Lancet*, August 18, 1888.

THE affection was due to adductor paresis, and was cured by external use of faradism. There was nothing noteworthy in the case except the age of the patient. **R. Norris Wolfenden.**

LOEB (Frankfort-on-Maine).—**Some Remarks on Enlargement of the Thymus Gland in Young Children.** *Deutsch. Med. Woch.*, No. 54, 1888.

THE author records the cases :—

1. Of sudden death of a girl, three months of age. The autopsy proved merely an enlargement of the thymus.

2. Of a boy, seven months of age, who had a laryngismus stridulus, and died from catarrhal pneumonia. Notwithstanding the pneumonia to be situated on the left side, a few moist sounds were heard on the opposite side. The autopsy revealed enlargement of the thymus gland. **Michael.**

BRAMWELL, H. R. (Harlington).—**An Anomaly in Stammering.** *Lancet*, *February* 4, 1888.

THE anomaly consists of a "series of clonic contractions of certain of the flexor muscles of the right upper and lower extremities which invariably precede the commencement of a sentence, and occasionally also interrupt a sentence already commenced." **Hunter Mackenzie.**

NECK, &c.

BERENS, T. P. (Philadelphia).—**Angioma of the Thyroid Gland.** *Med. News*, *April* 14, 1888.

A FULL account of the history and autopsy of a case which the author considers unique. **John N. Mackenzie.**

GAUTIER.—Treatment of Exophthalmic Goitre. *Rev. Gén. de Clin. et Thér.*, May 10, 1888.

GRAVES'S disease is a general neurosis, and the precise locality is in the bulbo-protuberantial region. Hyperæsthesia of this region constitutes the primordial functional trouble, which is followed by functional

modifications of the pneumogastric and of the vaso-dilator mechanism. This hyperæsthesia is most common in patients predisposed to it by a neurasthenic or rheumatic constitution. Next to emotional causes, the principal determining causes are disturbances of the genital functions. These considerations induced the author to try antipyrin in the treatment of the affection, and in two cases he obtained a real success.

CHARCOT.—Exophthalmic Goitre. *Journ. de Lucas Championnière*, 1888.

A LECTURE delivered at the Salpêtrière. The professor insists on two new signs of the affection, viz., diminution of the electrical resistance, studied by Vigoroux—and very completely by Dr. R. Norris Wolfenden, *Practitioner*, 1887 (see abstract in this journal, May, 1888),—and tremor, studied by Marie—also completely by Dr. Wolfenden and Dr. Dawson Williams (see *British Medical Journal*, May, 1888). The knowledge of these two new signs is important, for there are many undeveloped cases which can thus be diagnosed. Hydrotherapy is a good method of treatment in exophthalmic goître, especially repeated applications of ice-bags over the cardiac region : but galvanization of the great sympathetic and faradization of the cardiac region succeed still better. **Joal.**

RENDU.—Exophthalmic Goître caused by Iodism. *Soc. Med. des Hôp.*, May 23, 1888.

THE author relates the case of a woman, twenty-eight years of age, affected with acute aortitis. Under treatment by iodide of potassium, in doses of two grammes daily, the signs of aortitis amended in proportion to the saturation of the system with iodine, but at the same time symptoms of Graves's disease began to develop, as evidenced by tachycardia, vaso-motor and thermic phenomena, and exophthalmos. **Joal.**

CAMERON, J. (Liverpool).—**Case of Bronchocele treated by Fluoric Acid.** *The Liverpool Med.-Chir. Journ.*, July, 1888.

AN enlargement of the thyroid, apparently following upon exposure to cold. The patient had been under treatment for a few weeks without benefit. He was given fifteen minims of the half-per-cent. solution of fluoric acid, and kept in bed on a restricted diet.

Steady amendment occurred, and fourteen months after commencing treatment a mere trace of the enlarged thyroid remains. This is the second case in which the author has seen beneficial results from administration of fluoric acid, and he ascribes some specific influence upon the gland structure to the drug. **R. Norris Wolfenden.**

SHAW, CECIL E.—The Electrica Resistance of the Body in Graves's Disease. *Prov. Med. Journ.*, May, 1888.

THE author gives notes of fourteen cases (nine of Graves's disease and five of simple goître), in which he made forty-six observations. The results of these are in accord with Dr. Wolfenden's demonstration of the

alteration in the resistance offered by the body to the passage of an electric current. All the cases of Graves's disease showed a marked lowering of this resistance. The electrical resistance, the author agrees with Dr. Wolfenden, thus becomes a most valuable aid to diagnosis between simple goitre and early or undeveloped forms of Graves's disease. Its importance is enhanced by the fact that only one of the cases investigated was what would be called a well-marked one, showing considerable exophthalmos, von Graefe's sign, &c., and all might have been unrecognized by a careless observer. **Maxwell Ross.**

REPORTS OF SOCIETIES.

British Medical Association.

Fifty-sixth Annual Meeting, Glasgow, 1888.

SECTION OF MEDICINE.

Dr. THEODORE WILLIAMS opened a discussion upon *The Value of Inhalations in the Treatment of Lung Diseases*, and remarked that the direct application of medicinal agents to the air-passages dated from Hippocrates, who used fumigations, employing a pot through the lid of which a reed passed conducting the vapour to the mouth, sponges being used to prevent scalding. The return to the use of inhalations of late years might be traced partly to the accumulation of proofs that various substances could be absorbed by the air-passages, and partly to the antiseptic system. The fact, however, that this direct mode of treatment had hardly held its own against the indirect mode of giving drugs by the stomach was presumptive proof that inhalations *per se* were inadequate for dealing with pulmonary diseases. The various methods of inhalation might be classified as follows:—1. Inhalation of gases, such as oxygen, nitrous oxide, atmospheric air (condensed or rarefied), or vapours of certain medicines (volatile) at low temperatures, as ether, chloroform, nitrite of amyl, and iodide of ethyl. 2. Moist warm inhalations. 3. Dry fuming inhalations. 4. Atomized sprays. 5. Respirators containing antiseptic substances. As regards the first of these methods, there could be no doubt of its efficacy, as the full physiological effects of the various drugs were thus obtained. If antiseptic agents could be pushed to the same degree, and the patient brought thoroughly under their influence, it was probable that the results in pulmonary disease would be much more successful than they were at present. The second method had the great drawback of saturating the air with watery fluid, and, according to the experiments of Dr. Hassall, it was very doubtful whether any considerable proportion of the medicaments used really reached the diseased area. This mode of treatment was useful in croup, laryngitis, pharyngitis, and in affections of the larger bronchi, but its utility in capillary bronchitis and phthisis was doubtful. He had performed a series of experiments to determine whether drugs were really absorbed by this method, and had found that turpentine was readily absorbed, but that iodine was not. This was the more remarkable, inasmuch as iodine was easily absorbed by the stomach.

Hæmoptysis had been rather frequent in connection with these experiments. Of the third mode there were examples in the case of Himrod's powder, the use of medicated cigarettes, the inhalation of iodine fumes, carbon cones, &c. The evidence available seemed to show that the drugs thus employed were more effectual if given by the mouth. The fourth method (atomized sprays) seemed ineffectual to cause the penetration of the medicaments to any depth, and was apt to cause hæmoptysis. The fifth method was a favourite one, and many inhalers were in use, of which he might mention Burney Yeo's, Coghill's, and Curschmann's. The radical effect of this method was that it impeded free respiration, the patient feeling like a muzzled dog. His conclusions were as follows :—1. That the success of inhalations as a mode of medication depended principally on the easy convertibility into gas or vapour of such substances as were clearly desirable for the purpose, 2. That, consequently, bodies which were volatilized at ordinary temperatures were more readily absorbed by the lungs than bodies which had to undergo combustion before conversion into gases. 3. That all moist inhalations where steam, watery vapour, or spray was the vehicle of medication, were but slowly absorbed by the lungs, and entered the circulation in small quantities, and in some cases not at all, the slow rate of pulmonary absorption contrasting strongly with the rapidity of gastric absorption of the same medicines when swallowed, as proved by their detection in the urine. 4. That medicinal inhalations were more useful in diseased conditions of the pharynx, larynx, and larger bronchi than in those of the alveoli and lung parenchyma. 5. That in pulmonary disease the antiseptic respirators, while they lessened cough and reduced expectoration, exercised no lasting remedial influence upon the morbid condition, and did harm by impairing freedom of respiration.

Dr. Andrew Smart (Edinburgh) exhibited a new species of inhaler for fitting into the nose. He had a strong belief in the efficacy of inhalation, his patients frequently expressing their sense of the benefit which they derived from their use. He regarded creosote as one of the most valuable remedies in this mode of treatment, but advised its dilution.

Dr. Lindsay (Belfast) said he had given inhalations an extensive trial, and was disposed to regard them as of considerable value in affections of the bronchial tubes, but as of very doubtful utility in diseases of the lung-tissue proper. In acute bronchitis inhalation of simple steam was a remedy of great value, lessening spasm and promoting secretion. In chronic bronchitis inhalations impregnated with turpentine, carbolic acid, or creosote were valuable for improving the character of the expectoration. The real controversy in the question raged rather round the value of inhalations in phthisis. He had begun their use with hope, but his results had been mainly negative. He feared the amendment so often reported by patients from the use of inhalations, as stated by Dr. Andrew Smart, was exceedingly fallacious. Patients liked active treatment, and were very partial to novel remedies. To the so-called bacillicide treatment of phthisis there were, in his opinion, three strong objections :—1. It was not clear that the destruction of a microbe so tenacious of life as the bacillus of tubercle could be effected by any inhalations at our command. 2. If the bacillus could be destroyed, the receptivity of the patient to fresh infection would remain, and so nothing material would have been effected. 3. The adoption of warm inhalations, and the use of inhaling chambers, &c., were very prejudicial to that hygienic treatment of phthisis of the value of which there could be no question. Whatever success in the treatment of phthisis he had seen in his own practice, or that of others, had been obtained by a radically different method—viz., by aiming at improving the constitutional condition, and thus lessening the receptivity of the patient. This was effected by the

rigid regulation of the mode of life, by diet, by tonic remedies of various kinds, and, when possible, by change of climate.

Dr. IRELAND (Edinburgh) had had considerable experience of the pine forests of the Himalaya, and he had certainly seen some cases of early phthisis which had seemed to derive benefit from their residence among them.

Dr. COGHILL (Ventnor) had given great attention to this line of treatment, but it had not hitherto quite realised the expectations which he was inclined at first to expect from it. He was convinced, however, that it was founded upon a correct pathology, and thought it the duty of the profession to persevere in their investigations, in the hope of discovering some agent that would fulfil the necessary conditions. He had seen considerable advantage from inhalations in phthisis, bronchitis, and bronchiectasis. He was against the use of oro-nasal inhalers. He was disposed to think that medicated inhalations reached the diseased portions of the lungs specially.

Dr. SMITH (Netley) wished to say a few words upon his extensive experience of India. He protested against sending consumptives to that country, as, during the hot, damp weather of the monsoons the disease progressed with much greater rapidity than at home. He had been struck with the utility of inhalations most of all in a class of case which had come much under his notice—viz., where a hepatic abscess ruptured into the lung. He had seen hectic fever controlled by Coghill's inhaler and inhalations. He had been in places where the inhabitants attached great value to inhaling the fumes from kerosene wells, &c.

Dr. DENISON (Colorado) said he thought there was less and less effect obtained from inhalation as we went from the large bronchi towards the periphery of the lung. It should be remembered that in phthisis recovery was brought about by the development of fibroid tissue; hence it was probable that the inhalations go to the open alveoli—*i.e.*, to the healthy portions of the lungs. There was no medicament at all in the air which he regarded as the most useful in phthisis—viz., the cold dry air of high altitudes. In dry climates there was much more moisture exhaled from the lung than in humid climates, and the exhaled moisture was probably a vehicle for carrying off the bacilli.

Dr. GIBSON (Newcastle-on-Tyne) advocated the use of dry-powder inhalations, such as nitrate of silver and sulphate of copper, diluted with dried sugar or lycopodium.

Dr. BRETT (Watford) thought there was truth as well as wit in the saying that "Patients die because they won't expire." Free respiration was essential in phthisis.

Dr. WILLIAMS, in reply, expressed his gratification that the discussion had, in the main, served to substantiate the views put forth by him in his opening address.

SECTION OF LARYNGOLOGY.

The PRESIDENT (Dr. Semon) having delivered an address, in which the present favourable condition of laryngology in this country was commented upon, the necessity of enforcing a knowledge of the use of the laryngoscope at medical examinations was referred to, and the formation of the British Laryngological and Rhinological Association was condemned, and the advance of specialism in throat and nose diseases was unfavourably regarded;

Dr. MACINTYRE (Glasgow) introduced a discussion on *Nasal Stenosis*, and entered into the symptoms, pathology, and treatment of simple catarrh of the turbinated bones, to which he confined his remarks. He also entered into the question of reflex neuroses, giving his experience of these. He insisted on the

necessity of prophylaxis, a question of great importance to the general practitioner, and of constitutional as well as local treatment, referring to the use of the galvano-cautery, which he largely employed. He showed a number of instruments devised by himself for these purposes, as well as a switch-table for heating and lighting as required in diseases of the throat. In conclusion, the subject of necrosing ethmoiditis was discussed.

Mr. CRESSWELL BABER (Brighton), who followed, laid stress on the effects of nasal stenosis on the physiognomy, voice, and chest, and the senses of hearing and smell. In the treatment, he recommended for mucous polypi their removal with the cold snare and galvano-cauterization, and for adenoid vegetations removal with the finger-nail or forceps.

Remarks on the Pathology of Ecchondrosis of the Triangular Cartilage, with a New Operation. By GREVILLE MACDONALD, M.D.

THE usual co-existence of deflection of the triangular cartilage with ecchondrosis points to a common cause. Such asymmetry is unknown in infancy, and is therefore not congenital. It is frequently developed at puberty or in early adult life, although often at any subsequent period. Occasionally the stenosis dates from a traumatic cause, which, coupled with the fact that men are far more frequently attacked than women, and that boys are more liable to blows on the nose than girls, indicates the likelihood that traumatism is more often an etiological factor than is supposed. In such cases, the hypertrophy, which is inversely proportionate to the angle of deflection, has replaced the callus developed in the process of repair.

Other cases, doubtless, occur in which there is no traumatic element. Such are usually accompanied by a chronic rhinitis, generally hypertrophic, and frequently polypo-poietic. In all probability we here have a perichondritis, just as periostitis, the former being chondriophytic as the latter may be osteophytic. This will result in a hypertrophy of the cartilage in every diameter; and as the upper and lower boundaries are fixed, the increase in the vertical measurement necessarily results in a bowing of the septum to one or the other side. The operation I have lately adopted in preference to all others consists in separating the perichondrium with a raspatory, and then paring away the cartilage. The great advantage in this lies in the fact that no mucous membrane is destroyed. Healing occurs very rapidly. **The Author.**

Nasal Obstruction, by J. DUNDAS GRANT, M.A., M.D.

THE paper was founded on observations made on 200 cases of nasal obstruction, treated by the author within the last few months, and in all of which there was constant or habitual inability to breathe through the nose alone. The *conditions occasioning obstruction* were, in 102 cases, chronic hypertrophic rhinitis, in one subacute rhinitis, in eight polypi, in twelve septal deformity (uncomplicated). In fifty-five septal deformity with hypertrophic rhinitis, in one septal abscess following hæmatoma, in eighteen post-nasal adenoids, in three hypertrophic rhinitis with post-nasal adenoids. In the majority of cases of hypertrophic rhinitis, there was a combination of vascular turgescence, infiltration, and hyperplasia, in varying proportion. Diseased bone was scarcely ever detectable.

Among the chief *causes* were exposure to dust, cold, and irritating fumes; injury and nerve-exhaustion, the last being both an effect, and (through vaso motor influences), a cause of nasal obstruction; the two, when coexistent, acting in a vicious circle of reciprocal intensifications. The list of *symptoms*, *results*, and *accompaniments* included loss of smell and taste; disturbances in the regions of

the throat and ear, such as deafness, tinnitus, otorrhœa, sore throat, dryness of the mouth and dyspnœa (often paroxysmal). Also nervous affections, such as restlessness, headache, mental dulness, tremors, stammering, &c. The remarkable improvement in these respects, as soon as the nasal obstruction was removed, and their obstinacy up till then, afforded evidence of their dependence on that condition. In one case a patient, to whom quiet sleep was a stranger, enjoyed fourteen hours of uninterrupted repose after an operation on his deviated septum.

General treatment depended more on the collateral condition, the removal of causes of nerve-exhaustion being of considerable importance.

The chief points connected with *local treatment* were :—

Instruction in the art of nasal breathing.

Douches of a mild alkaline and anti-septic nature followed by the application of an antiseptic *ointment* (curative in a large number of the milder cases), *cocaine* application in acute cases.

Nasal dilating tubes (as made by Coxeter) for cases of slight swelling with a minimal degree of septal deviation, especially when further more expeditious operative treatment was declined.

Galvano-caustic puncture with a fine point driven deeply into the tissues, especially the turgid cavernous portions. In twenty-three cases there was immediate and lasting relief without any degree of discomfort from the operation. The most effective mode of treatment.

Superficial galvano-cauterisation and *chemical caustics* (chromic acid), effectual in many cases, but sometimes exciting middle ear inflammation. Slower in producing result than the puncture, and leaving a larger margin of non-success. The use of the chromic acid (deliquesced crystals) was rendered safer by the employment of Dr. Hill's guard.

Nasal-splints, designed by the writer, were used after forcible straightening of the bent septum by means of Adams's forceps. They were found more easy to apply than the plugs and supports previously in use.

Galvano-cautery point, for perforation of the septum behind the projecting angle, restored comfort in a few cases.

Nasal trephine, worked by dental engine or electric motor, afforded the least painful and most expeditious means of restoring breathing. Occasionally the small ridges above and below the round channel required to be removed with a few touches of the nasal saw. In ten recent cases only one suffered any inconvenience subsequent to the operation, owing to indiscreet exposure to cold. A plug of iodoform wool should be retained for a few hours, an aperient draught taken, and exposure to cold for a couple of days carefully avoided.

The *nasal saw* is rather slower in its action, but is as well or better adapted for removing flat wide-based horizontal outgrowths. In five cases recently operated on there was immediate relief with absence of hæmorrhage or inflammatory reaction.

When applicable the author used the *galvano-caustic snare* for the removal of polypi or pendulous outgrowths, but in many cases only the *cold-wire snare* could be used. The latter was more painful and more apt to be accompanied by hæmorrhage. Its use was followed by the application of the galvano-caustic point. The author thought recurrence less likely after the galvano-caustic than after the cold snare. The application of the snare was much facilitated by the introduction of a *finger behind the soft palate* into the naso-pharynx.

A combination of these plans of treatment was frequently required.

For the removal of post-nasal adenoids the author used the *finger nail* alone in

minor cases, but in the more marked cases he found the greatest advantage from scraping the growths up from the back wall to the roof of the pharynx, and then lifting them away with Schech's *post-nasal forceps*. He preferred a *leather finger-guard* to the rigid or jointed metal ones, as allowing the finger to be more freely used.

He thought there was need for the co-operation of the general physician and the rhinologist in many cases. **The Author.**

A discussion followed, in which Drs. Stoker, Hunt, Hodgkinson, Roe, Hall, Spicer, Newman, and McBride, took part. The majority favoured the use of the cold snare in the removal of mucous polypi, although all recommended the destruction of the base with some agent, which would prevent return. To secure this it was necessary to keep the patient under observation for some time after operation.

Drs. Macintyre, Baber, and Grant having replied, the President summed up the discussion.

The other papers read were: Hay Fever and its Allied Conditions, by Dr. Peter McBride; Account of a Case of Tumour of the Naso-Pharynx, by Dr. R. McKenzie Johnston; Remarks on the Removal of Naso-pharyngeal Polypus, with specimen, by Dr. Christopher Lewis; Cases of Fibro-mucous Polypus of the Naso-Pharynx, by Dr. C. Warden.

On Friday, Dr. PERCY KIDD (London) opened the discussion on *Hæmorrhages from the Pharynx and Larynx*, and said that his opinion was that, apart from ulcerating carcinoma, suppuration, and traumatism, hæmorrhage from the pharynx and larynx is very uncommon, nearly always slight, and practically devoid of importance. In most cases of so-called hæmorrhage from the throat, the larynx and pharynx are not actually concerned, the blood coming from the lung or from the cavity of the nose or mouth.

Dr. HODGKINSON (Manchester) next read a paper, and stated that hæmorrhage was of importance, partly on account of its moral effect, which was great, but chiefly as an indication of serious organic disease. He spoke of the difficulty of truly interpreting the various signs and symptoms—firstly, because small hæmorrhages from the lungs occur without giving evidence to us by thermal or stethoscopic examination; secondly, the anatomical relationship of the parts in question are so close that blood easily passes from one region to the other. In doubtful cases it is necessary to enjoin precautions necessitated by pulmonary lesions, rather than to conclude it to be from the throat.

A discussion followed.

Dr. ERNEST JACOB read a paper entitled *Some Unusual Forms of Laryngeal Stenosis.*

Three cases.—1. *Falsetto voice occurring after hemiplegia*, three years before. This occurred only at intervals. Proper phonation took place under examination. This was compared to the high head voice, occasionally elicited in cases of functional aphonia in young women under faradism.

2. A man of twenty-five had strained his voice five days before, singing. Attempts at phonation produced a violent spasm of inspiration of hysterical character, and no sound could be uttered. After a spray of cocaine, examination showed the larynx injected, and phonation was accomplished normally, but the voice was hoarse.

3. A boy of twelve could speak only in explosive monosyllables after great effort. There was a history that five months before a teacher at the school had

"knocked him down, seized his throat, and nearly strangled him." He had not been able to speak properly since. Normal phonation occurred after the passing of a constant galvanic current through the larynx. **The Author.**

The other papers read were: A case of Lupus Vulgaris of the Upper Respiratory Tract, with Polypus (Lupus) of the Larynx, by Dr. R. H. Spicer; also by the same gentleman, Clinical and Pathological Observations in Affections of the Tonsils (Faucial, Lingual, and Pharyngeal), in the light of recent views as to their functions; Notes on Tonsillitis and Tonsillotomy, by Dr. Christopher Lewis; Dr. T. Middlemass Hunt on Acute Epiglottitis, a question of Nomenclature.

Dr. SEMON, at the end of the day's sitting, congratulated the members on the successful way in which the meetings had been conducted. He thought much valuable information had been obtained by each from the discussions which had been so thoroughly and enthusiastically taken up. He thought that this Section had now fully established its claim to be a distinct and separate one.

SECTION OF ANATOMY AND PHYSIOLOGY.

On the Mechanics of the Nose, in Relation to Respiration, Smell and Taste. By GREVILLE MACDONALD, M.D.

CERTAIN experiments I have recently made on the alteration in temperature, and hygrometric condition of the inspired air, by passing through the nose, give some interesting results. Thus, when the external temperature stands

At – 7° C	the air is raised to	28.8° C;
At 1.7° C	,,	,,	35° C;
At 7° C	,,	,,	34° C;
At 12° C	,,	,,	35.6° C;
At 45° C	,,	reduced to	33.6° C;

These are a few results of a great number of experiments on different individuals. *Cæteris paribus* the robust raise the temperature two or three degrees higher than the anæmic. Cocaine inducing collapse of the inferior spongy bodies will lessen the acquired temperature by 2° or 3° C—a valuable point as indicating the importance of these structures.

In estimating the quantity of aqueous vapour absorbed, I find it varies considerably, according to the barometric pressure in the nose, this obviously lessening when there is any degree of stenosis in the nose. In the latter case, with an artificial obstruction, I find the weight of aqueous vapour may even double that of saturated air at the external pressure. Ordinarily there must always be a minus-pressure in the nose during inspiration, and a plus during expiration. Cocaine has the effect of slightly lessening the amount of moisture absorbed.

Remembering the latent heat of aqueous vapour, one realizes the enormous quantity of heat given up by the nose.

Further, I show how the middle meatus bears as important a share in respiration as the inferior; and suggest reasons for assigning to the superior spongy body the function of taste, leaving the middle and septum for the sense of what is subjectively distinguished as smell. **The Author.**

Professor RUTHERFORD thought that the question as to the appreciation of sense of flavour or taste by the superior spongy bone deserved further investigation.

Professor CLELAND referred to the supply of Jacobson's organ in the sheep with branches from the olfactory nerve and from Meckel's ganglion.

In the *Museum*, Drs. NORRIS WOLFENDEN and SIDNEY MARTIN exhibited drawings illustrative of Laryngeal Growths.

Bradford Medico-Chirurgical Society.

December, 1887.

Mr. BRONNER, ADOLPH.—*Post-Nasal Growths.*

OF ninety-eight cases of disease of the middle ear in children under fifteen years, seen by the author, fifty-two had post-nasal growths; and of eighty-one cases of post-nasal growths, seventy had diseases of the middle ear.

Dr. MAJOR drew attention to the effect of post-nasal growths in causing contracted chest in children. **Hunter Mackenzie.**

Sunderland and North Durham Medical Society.

March 15, 1888.

Mr. MACKAY.—*Tracheotomy.*

EXHIBITION of a woman on whom this operation had been performed eleven years previously. Since then she had had five children, but had never been able to do without the tube. [The absence of the *raison d'être* of the tracheotomy renders the case incomplete.—REP.] **Hunter Mackenzie.**

West London Medico-Chirurgical Society.

April 6, 1888.

Dr. ALDERSON.—*Calculus in a Tonsil.*

EXHIBITION of a concretion, about half an inch long, which had sloughed out of the tonsil of a patient aged seventy-two.

Mr. KEETLEY.—*Large Wen in the Neck treated by a New Method.*

AN old-standing wen which extended from the jaw to the clavicle, was successfully treated by removing an elliptical piece, turning out the contents, thoroughly cleansing the cavity, stitching the hole in the cyst to the hole in the skin, and plugging the cavity with strips of iodoform gauze. Fixation of the head and neck by a poroplastic apparatus is supposed to have materially contributed towards success. **Hunter Mackenzie.**

Brighton and Sussex Medico-Chirurgical Society.

February 2, 1888.

Dr. MACKEY.—*Clinical Remarks on Resorcin, &c.*

PAPER read.

Mr. CRESSWELL BABER had found a spray of 20 per cent. solution of resorcin combined with cocaine more efficacious in a case of epithelioma of the fauces than a spray of cocaine alone, although it had no effect in arresting the disease.

March 1, 1888.

Mr. CRESSWELL BABER.—*Treatment of Laryngeal Phthisis and Abscess of the Antrum.*

RECOMMENDS injection of menthol into the larynx for laryngeal phthisis. Contains nothing new. **Hunter Mackenzie.**

Northumberland and Durham Medical Society.

February 9, 1888.

Dr. BRADLEY.—*Aneurysm of the Aorta.*

SPECIMEN shown, which had burst into the œsophagus.

March 8, 1888.

Mr. RUTHERFORD MORRISON.—*Rhinoplasty.*

AN exhibition of photographs, showing effect of plastic operations.

Dr. LIGHTFOOT.—*Tubercular Laryngitis.*

PAPER held as read. **Hunter Mackenzie.**

Harveian Society of London.

March 1, 1888.

Dr. SCANES SPICER.—*On the Functions of the Uvula and Epiglottis.*

THE author describes a function which has hitherto escaped detection—that the uvula serves during normal breathing as a guide to convey the nasal and lachrymal secretions out of the breath-way on to the lingual tonsil, there to undergo re-absorption into the circulation. These fluids are delivered on to the base of the tongue in a plane anterior to the epiglottis. From the lingual tonsil the unabsorbed portions trickle into the glosso-epiglottic fossæ, and thence into the pyriform sinuses or hyoid fossæ, along the lateral grooves of the epiglottis. It was mentioned that previous authors had considered the uvula as a conductor or dripping-stone, to convey mucus, etc., into the larynx for lubricating purposes, or to the base of the glottis, where it accumulates until swallowed or hawked up. Common experience teaches us that such intrusion of fluids into the larynx as is assumed or inevitable, causes cough and spasm. The functions of the epiglottis were next considered. It was pointed out that the balance of favour was against any deglutitive function of the epiglottis; but in favour of its movements and position having an important connection with the pitch, intensity, and quality of the voice. **Hunter Mackenzie.**

Anatomical Society of Great Britain and Ireland.

February 8, 1888.

Professor CURNOW.—*Double Arch of Aorta, enclosing Trachea and Œsophagus.*

Specimen shown. **Hunter Mackenzie.**

Royal Medical and Chirurgical Society.

March 13, 1888.

Dr. HALE WHITE.—*On the Naked-Eye and Microscopical Variations of the Human Thyroid Body.*

THIS communication was founded on the examination of forty thyroids taken casually from patients dying in Guy's Hospital. The size of the organ was very variable, being, as a rule, smaller in adults over fifty than in those under fifty. The research showed that atrophy of the gland did not invariably produce myxœdema.

Dr. CHEADLE thought it important that Dr. White had found complete atrophy of the thyroid without myxœdema. He considered the myxœdema to depend partly on the early age at which the atrophy occurred, and to be of very slow onset.

Mr. J. BERRY had seen, at Geneva, a case in which the thyroid had been completely extirpated for five years, but which showed no signs of myxœdema

beyond anæmia. Artificial myxœdema was much less marked than the disease, and ought rather to be indicated as cachexia strumipriva.

Dr. WHITE said that in cases of atrophy with pressure on the recurrent nerve, observed by him, there had been no pressure on the vessels. In the case in which he had found complete atrophy after death, Dr. Wilks had, during life, noticed no signs of myxœdema.

Hunter Mackenzie.

Midland Medical Society.

January 25, 1888.

Mr. LLOYD OWEN.—*Abscess of Frontal Sinus.*

EXHIBITION of case successfully treated by opening and free drainage.

Hunter Mackenzie.

Pathological Society of Manchester.

February 8, 1888.

Dr. T. HARRIS.—*Sloughing Ulceration of the Larynx.*

SPECIMEN shown. In this case the laryngeal lesion was not suspected during life. During the last three or four days of the patient's life his voice was feeble and slightly hoarse, and his breath was very offensive; there had been some bloody expectoration, but no evidence of laryngeal obstruction existed. At the post-mortem examination there was found (in addition to cardiac lesions) a patch of sloughing on the left side of the interior of the larynx, which extended to and destroyed the posterior half of the vocal cord. There was no necrosis of cartilage The patch was evidently of quite recent and acute origin. There was no foreign body in the larynx, nor any evidence of syphilis in any of the organs.

Dr. T. HARRIS.—*Sloughing Pharyngitis.*

THIS was an exhibition of "a rare specimen of sloughing of the pharynx. The disease, which was not diphtheritic, had extended to the larynx, and rendered tracheotomy necessary. The specimen was from a man, aged sixty, and the disease had commenced six days before death."

[The latter case is probably of the same nature as those to which the term "acute infectious pharyngitis" has been applied by Senator (*Berlin. Klin. Wochen.*, 1888, Nos. 5 and 6). It has also been recently described as "pharyngitis submucosa phlegmonosa." Its origin and cause appear to be quite unknown.—REP.]

Hunter Mackenzie.

Leeds and West Riding Medico-Chirurgical Society.

February 3, 1888.

DR. JACOB.—*Laryngeal Papilloma.*

EXHIBITION of microscopic sections of recently removed growths.

February 17, 1888.

MR. ADOLPH BRONNER.—*The Treatment of Empyema of the Maxillary Sinus.*—THIS condition was described as being liable to be produced by disease either of the teeth or nose, but in most cases the author thought it was secondary to a condition of hypertrophic rhinitis, the disease of the teeth being secondary to this. He preferred opening from the middle of the meatus of the nose.

MR. TEALE said he had lately been treating chronic post-diphtheritic paralysis.

[The case seems to be one of simple tonsillitis.—REP.]

March 2, 1888.

Mr. JESSOP.—*Simple Perforating Ulcer of Septum Nasi.*

RECORDS of four cases. In one only was there the faintest suspicion of a syphilitic history. Mr. Jessop commented on the slow course of the ulcer, its uniform character, and the absence of fœtor or discharge. It appeared a condition of middle life, and was favourably affected by local remedies.

Dr. CHURTON referred to certain cases of ulceration of the tongue shown by Mr. Hutchinson to be curable by opium, and he suggested the use of that drug in simple nasal ulcers.

Dr. JACOB referred to lupus, typhoid, and rheumatism as causing perforation of the nasal septum.

Dr. BARRS described a case with anomalous nervous symptoms, in which there eventually supervened a condition of progressive ulceration of the nose, without discharge or fœtor. It was neither lupus, rodent ulcer, nor syphilis.

Dr. A. BRONNER referred to the researches of Zuckerkandl, who found, in 180 necropsies, the septum perforated in eight. He thought perforation might be the result of nasal catarrh with scabbing, so common in children.

Hunter Mackenzie.

Sheffield Medico-Chirurgical Society.

February 4, 1888.

PYE-SMITH.—*Nerve Section for Wry Neck.*

CASE exhibited, in which, after operation, the movements had almost entirely ceased.

MAKEIG JONES, W.—*Myxœdema.*

EXHIBITION of a woman, aged fifty. Amongst other indications were slowness of speech and stammering; unpleasant taste, but not smell; the thyroid, especially in its left lobe, was larger than in women of the same age. Although speech was slow, she could read fluently.

March 15, 1888.

Dr. HUNT.—*Large Indurated Glands removed from a Child's Neck.*

EXHIBITION of specimens.

Mr. BALDWIN.—*Exophthalmic Goître.*

PARTICULARS of case related, but not reported.

March 29, 1888.

Mr. S. ROBERTS.—*Hypertrophy of the Gums.*

EXHIBITION of a boy with this affection.

Dr. MARTIN.—*Terebene.*

PARTICULARS of three cases of blennorrhœa treated by internal administration of 10-minim doses. Stress was laid on the necessity of seeing that the kidneys were healthy before using this drug.

Hunter Mackenzie.

Nottingham Medico-Chirurgical Society.

January 20, 1888.

Mr. JOSEPH WHITE.—*Malignant Disease of Larynx.*

A PAPER dealing with one case of intrinsic, and one of extrinsic, carcinomatous disease of the larynx, which contains nothing new.

Hunter Mackenzie.

Plymouth and Devonport Medical Society.

March 17, 1888.

Mr. JACKSON.—*Whooping Cough.*

A DISCUSSION on the remedies for this complaint, which contains nothing new.

Hunter Mackenzie.

Seventeenth German Congress of Surgery.

BERGMANN (Riga) showed a patient in whom the larynx had been extirpated three years previously on account of carcinoma. There has been no recurrence. The patient speaks now in a whisper. An artificial larynx cannot be supported.

Michael.

French Society of Otology and Laryngology.

(*Continued from page* 283.)

M. BERGER (*Gratz*).—*Symptoms of Disease of the Sphenoidal Sinus.*

IF the affection is limited to within the sinus, all objective symptoms may fail, or intense cephalalgias may occur. If the disease is propagated to neighbouring parts, there is observed, in caries and necrosis of the sphenoidal bone, sudden unilateral blindness, meningitis, sudden fatal hæmorrhage, retro-pharyngeal abscess, thrombosis of the cavernous sinus and ophthalmic vein, or pieces of bone are extended through the nose.

In cases of tumour, there is at the commencement no symptom, or only cephalalgia. If there is compression of neighbouring organs, of the optic nerves, amaurosis may follow. When the tumour perforates the base of the cranium, meningitis follows, or cerebral abscess is formed. Wounds of the body of the sphenoid bone may produce the following symptoms:—Continuous flow of cephalo-rachidian fluid, pulsating exophthalmos, destruction of the optic nerve, and amaurosis; anæsthesia of the second and third branches of the trigeminal.

M. BARATOUX.—*On a Form of Nasal Stenosis.*

THE author has observed a series of deviations of the septum, with development on one or both surfaces of a cartilaginous or an osseous mass, completely obstructing the nasal cavity. The deviation is usually of the left side; it seemed to be the consequence of adenoid tumours in eight patients. In two cases it was attributed to traumatism. M. Baratoux employed the saw in all cases except one, which was a case of cartilaginous tumour and deviation of the anterior part of the septum, with obstruction sufficient to prevent the passage of a fine laminaria stem. Under laminaria, the cartilaginous tumour has almost disappeared, and the deviated septum has regained its normal position.

M. MOURE.—*Acute Abscess of the Septum.*

THE case of a young girl of twenty, sympathetic, and affected with abscess of the septum as the result of exposure to a draught. The symptoms resembled those of facial erysipelas, except for more marked œdema of the eyelids, and notable swelling of the mucous membrane of the septum at the orifice of the nostrils, and a very intense naso-frontal headache. A flow of blood and pus from the nose occurred eight days after the onset of the affection, and led to local and

general amendment. Sinking in of the nasal bone has resulted in external deformity of the nose.

The Committee of the Society for 1888-89 was elected as follows :—

For *Paris.*—MM. GELLÉ, GOUGENHEIM, and MIOT.

For the *Provinces.*—MM. AIGRE (Bologne) and NOQUET.

Foreign—MM. BERGER (Gratz) and SCHIFFERS (Liege).

Joal.

NOTE.

IN the abstract of Mr. Mark Hovell's paper on *Cystic Goître* (p. 310), instead of "two grms. of the salt to one oz. of water," read two drachms (℥ij).

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés *d'envoyer un numéro de tout journal* contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Um die rechtzeitige Veröffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W., zu senden.

London : Paradon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

CONTENTS.

Original Article, p. 355.—Observations on Graves's Disease (continued). DR. NORRIS WOLFENDEN.

New Instruments and Therapeutics, p. 363.—WEIL: Palate Hook. JAMES: Pneumatikon. RUSBY: Cocillana Bark. BROOKS and DUTT: Antipyrin. RHYS: Cocaine in Tonsillitis. JOY: Poisoning by Stramonium. FERGERS: Quinine in Whooping Cough. TABOADA: Waters of Alhama in Catarrh. VALENZUELA: Respiratory Therapeutics. COMPAIRED: Hydro-Therapeutic Treatment of Ozæna. STOKER and HALL: Local Treatment of the Upper Air-passages.

Diphtheria, p. 366.—MARIANI: Two Forms of Diphtheria in Prognosis. JACUBOWITSCH: Chronic Diphtheria and Perichondritis in Children. PINIAZEK: Prevention of Suffocation after Tracheotomy. BARBIER: Albuminuria. CLEMESHA: Tracheotomy.

Mouth, Tonsils, Pharynx, etc., p. 368.—SHEPHERD and HUNT: Glossitis. HEATH: Diseases of the Tongue. CASTELO: Deep Fissure of the Tongue. RUAULT: The Pathology of the Fourth Tonsil. LE DENTU: Neoplasms of the Hyoid Bone. VERNEUIL: Subhyoidean Phlegmon. CHAMPIONNIERE: Guttural Reflex in Utero-ovarian Operations. PONCET: Adeno-Chondroma of the Palate. TRÉLAT: Ribbon Ligature. ROUSSEAU: Acute Infectious Amygdalitis. DU CASTEL: Early Syphilitic Angina. JAMISON: Hæmorrhagic Pharyngitis. KIDD: Hæmorrhages from the Pharynx, Larynx, etc. MILLS: Case of Profound Lightning Shock. SCHAEFFER: The Pharyngeal Bursa and Tonsil. MOLLER: Case of Subhyoidean Pharyngotomy. MORENO Y DESVERNINE: Œsophagotomy for Foreign Body in Gullet. PLICQUE: Cancerous Strictures of the Œsophagus.

Nose and Naso-Pharynx, p. 374.—BOSWORTH: Physiology of the Nose. HAJEK: The Bacteria of Acute and Chronic Coryza and Ozæna. KŒHLER: Rhino-scleroma. GAUCHER: Epistaxes in Nephritis. OLIVIER: Tertiary Syphilis of the Nose, etc. BRONNER: Ozæna. MENOCAL: Naso-Pharyngeal Polypus. SCHROETTER: A Peculiar Form of Inflammation of the Choanæ. LINK: Empyema of the Antrum, DOUBRE: Elephantiasis of the Nose. LARRAUD: Recurrent Erysipelas in a Case of Tornevaldt's Disease. WEIL: On Adenoid Vegetations.

Larynx, p. 377.—CHEATHAM: Report on Laryngology. AREITZA: Aphonia and Aphasia treated by Hypnotism. LENNOX-BROWNE: Case of Traumatic Perichondritis. MORRIS: Two Cases of Laryngotomy. CASADESUS: Impaction of Pin in Left Vocal Cord. SORENSEN: Division of Posterior Wall of Trachea by Tracheotomy. GRASER and HARVIE: Intubation. PALMIÉ and MICHAEL: Tamponading the Trachea. CHIARI: Tracheal Stenosis Seven Years after Diphtheria. X: Pine Nut in the Trachea.

Neck, p. 380.—TRESILIAN: Myxœdema. ZOEGE: Echinococcus of the Thyroid Gland. PILLIET: True and Supra-Renal Goitre. KAHLER, SMITH, and SOUZA LEITE: Graves's Disease.

Societies, p. 382.—Finnish Physicians; Pathological Society of London; Clinical Society; Brighton and Sussex; Manchester Pathological; Leeds and West Riding; Medical Society of London; South-East Hants; Royal Medical and Chirurgical; Hunterian; Manchester Medical; British Medical Association—Branches; Clinical of Manchester; Montreal Medico-Chirurgical.

Reviews, p. 386.—Baratoux, Cancer in Larynx; The Illustrated Medical News.

New Preparations, p. 387.—Stretton Waters; Vapour Cones and Cases.

Note, p. 388.—Roaring in Horses; The British Laryngological and Rhinological Association.

MODERN PHARMACY.

SACCHARIN.



This new agent, which is now attracting such universal attention, we supply in the form of beautiful Tabloids, ½ grain each, quickly soluble. This new substitute for sugars in diabetes possesses 300 times the sweetening power of cane-sugar; non-fermenting, and a powerful antiseptic; positively harmless, and quickly excreted by the kidneys unchanged. "The most remarkable of all the coal-tar products."—SIR HENRY ROSCOE.

Many of the saccharin preparations in the market have a peculiar taste; are insoluble, and contaminated with mannite, sugar of milk, colouring matter, and other impurities. Mannite is formed in the lactic acid fermentation of sugar, from glucose, cellulose, and invert cane sugar, so that it has a close relationship with sugars, and is only given with risk in diabetes, as is also milk sugar. When a diabetic patient is given Saccharin it is with the aim of avoiding sugar, which is prohibited and considered poison in this disease. To mix saccharin with sugar defeats the object in view, and can have no foundation in reason, as sugar possesses only 1/300 part of the sweetening power of pure Saccharin.

These Tabloids of compressed Saccharin are absolutely free from sugar, and contain the original and purest product (as discovered in the laboratory of Professor Remsen). They are freely soluble.

One or two tiny Tabloids of Saccharin added to a cup of tea, coffee, or cocoa—in lieu of as many lumps of sugar—will impart to it a sweet and delicate flavour, and leave a pleasant remembrance on the palate. The **Saccharin Tabloids** are now being used on the tables of many distinguished people as a delicacy, in preference to the ordinary tea and coffee sugars, as it does not impair the aroma of the choicest tea or coffee.

Saccharin Tabloids supplied to the medical profession in packages at 4s., 8s., and 24s. per doz. Soluble Saccharin supplied in oval crystal glass bottles at 20s. per doz.

HAZELINE.

Of all the preparations of Hamamelis Virginica, this is pharmaceutically the one to be preferred. It contains an amount of the volatile active principles not found elsewhere. Hazeline is a uniform, pure and active medicament, and as pleasant to use as any drug that is used.

Supplied to the medical profession in 4-oz. and 1-lb. bottles, at 14s. and 42s. per doz.

LANOLINE.

Lanoline alone is said by Professor Frænkel, in CHEMISCHE ZEITUNG, to be an excellent application in incised wounds and burns. In incised or lacerated wounds, bleeding is said to cease immediately, and the wound may even be bathed in rapidly running water without removal of the Lanoline. In burns, also, it is said to be most excellent, and prevents the formation of crusts and the scabs, while entirely protecting the surface from atmosphere.—NATIONAL DRUGGIST, May 1, 1888.

For burns, especially made by exposure to the sun, and for inflamed states of the skin from any cause, the most eligible form of this unparalleled "unguent-basis" is Lanoline Cold Cream, which is of beautiful consistence, softens the skin and supplies it with a natural nutritive unguent.

Lanoline supplied to the medical profession in 1-lb. tins, at 3s. 6d. each. Lanoline Cold Cream supplied in pots at 14s. per doz.

REPORT ON ANTIPYRIN "TABLOIDS."

The LONDON MEDICAL RECORDER (June 20th, 1888), reports:—

"There has been forwarded to us a sample of Antipyrin 'Tabloids,' which, apart from convenience of dosage, etc., have the advantage of not being susceptible of adulteration after having left manufacturer's hands. As many of the inconveniences which have from time to time been reported as following the use of this drug are attributed to the presence of impurities of one sort or another, this is an important attribute."

One of these "Tabloids" is about the dose for subcutaneous injection. "Wolff gives in the THERAP. MONATS. details of fifteen cases, and states as his conclusion that the hypodermic injection of Antipyrin is very serviceable *in muscular Rheumatism*, in the chest-pains of phthisis, and for neuralgia, as well as for rendering the diagnosis of asthmatic affections easy, and in painful diseases when morphine is inapplicable."—CHEMIST AND DRUGGIST.

Tabloids of Pure Antipyrin supplied to the medical profession in bottles of 25 and 100, at 20s. and 70s. per doz. Antipyrin Crystals, at 3s. 5d. per oz. Special price to Hospitals.

SULPHONAL "TABLOIDS."

In the BERLIN KLINISH. WOCHENSCHRIFT, Drs. Rosin and Oestreicher give the results which they obtained with sulphonal. Dr. Rosin gave it 138 times to 88 patients, and Dr. Oestreicher 100 times in 50 cases. The average dose was about 35 or 40 grains. Rosin proved by control experiments that the consequent sleep was produced by the Sulphonal. Doses of 15 grains were not sufficient, but 30 grains (preferably in wafers, or compressed in Tabloids) gave satisfactory results without unpleasant secondary symptoms. The latter dose is regarded as equivalent to about one-sixth or a quarter of a grain of morphine, while a drachm would be equal to a third of a grain of morphine or 30 grains of Chloral Hydrate, and should only be resorted to in urgent cases.—CHEMIST AND DRUGGIST.

Sulphonal Tabloids supplied to the medical profession in bottles containing 25 and 100, at 36s. and 108s. per doz. bottles.

THE

JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. OCTOBER, 1888. No. 10.

Contributors of original articles receive Fifty Reprints gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

OBSERVATIONS ON EXOPHTHALMIC GOÎTRE (GRAVES'S DISEASE).

By R. NORRIS WOLFENDEN, M.D. Cantab.

(Continued from page 328.)

THAT the temperature is raised constantly in exophthalmic goître is shown by the notes of the following six cases, taken at random from my case book :—

1.	Marked	Exophth.	Goître	in a	woman.	Temp.	100°	Pulse,	158.
2.	Early	,,	,,	,,	man.	,,	100°	,,	90.
3.	,,	,,	,,	,,	woman.	,,	100°	,,	130.
4.	,,	,,	,,	,,	woman.	,,	99·8°	,,	104.
5.	,,	,,	,,	,,	woman.	,,	100·7°	,,	102.
6.	,,	,,	,,	,,	woman.	,,	100·5°	,,	140.

It would be easy to multiply these cases, but no object would be gained. The increase of temperature does not appear to bear any relation to any other of the physical phenomena, but it is real and constant.

Two symptoms merit detailed attention, namely, Tremor and the Diminution of the Electrical Resistance.

Tremor.—Every case in which the symptoms of this complaint are well developed, is marked by an exceedingly fine tremor. In the early stages this is even to be met with, and it forms an important symptom. The tremor is quite characteristic from its very fineness and rhythmical character, so fine, that, as Dr. Stephen Breckenridge—one of my clinical assistants—aptly remarked, it is "rather to be felt than seen." Every one is familiar with the tremor of chorea, of paralysis agitans, disseminated sclerosis, senility, paraplegia, etc. Some of these tremors are regarded as more rapid than others, and each form has been considered to possess distinctive characters of its own. This is undoubtedly true, and these movements, more or less rhythmical, vary much in their amplitude. Thus, one only requires to look upon a patient with paralysis agitans to observe the tremors at a glance ; but one often requires to take the hand of a person with Graves's disease, and lay it loosely on one's own palm, to notice the fine vibrations characteristic of the movements.

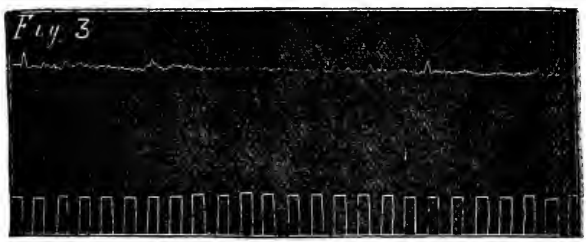
Thinking that a graphic record of the tremors in some of these conditions might help to throw some light upon their various features, I determined, along with my friend Dr. Dawson Williams, to carry out a series of experiments, having for their aim the recording upon a revolving drum tracings of these movements.

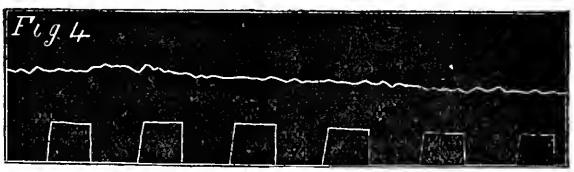
Our results were presented to the meeting of the British Medical Association in Dublin, and subsequently published in the *British Medical Journal.*

The method of taking these experiments was as follows :--

A recording cylinder and time marker (marking half-seconds) were placed in position, and to a Marey's tambour was attached a long glass tube (glass being used to diminish oscillation), at the extremity of which was applied an india-rubber tambour, which, placed in contact with the hand or other part of the patient's body, would register the muscular movements in the oscillations of the lever. The latter were recorded on the revolving drum.

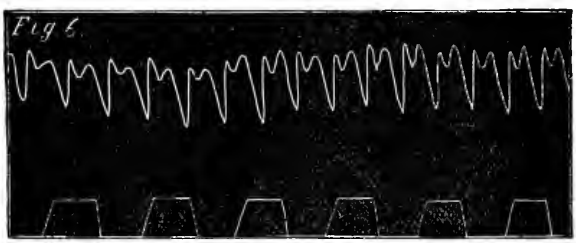
I give here tracings of the movements of Graves's disease :—



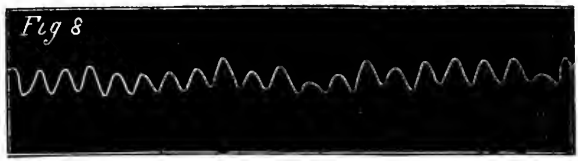


This tracing was taken with the drum revolving more rapidly.

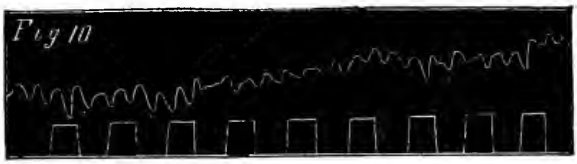
For the purpose of comparison I append tracings taken of paralysis agitans, disseminated sclerosis, and senile tremor :—



Paralysis Agitans.



Disseminated Sclerosis.



Senile Tremor.

On counting the tracings, the tremors differ little in rapidity, but vary much in amplitude, and it is this variation in amplitude that gives each kind of tremor its characteristic features.

Those tremors which gave a rate of only five a second on a slowly revolving drum, are really of the same rate as the finer and more rapid tremors, their characters being due to fusion or summation of the waves. I must refer to our original paper for further explanations as to these points.

Marie described the tremor of patients with Graves's disease, as "a perpetual vibration, and standing or seated, all the body seems to be in a continual tremor." The muscles of the trunk and extremities exhibit fine fibrillar movements; and in cases in which the tremor is less marked it must be looked for in the extremities of the upper limbs. Marie, who made graphic records (as we have done) of this form of tremor, described it as very rhythmical, consisting of series of oscillations, separated from each other by equal intervals, and each series affecting an increasing progressiveness, followed by a decrease, the whole exhibiting a spindle-shaped tracing. He estimated the number of vibrations at $8\frac{1}{2}$ per second, and spoke of it as quicker than senile tremor and general paralytic tremor,[1] but Dr. Dawson Williams and I did not notice the characters described by Marie. In our tracings of the tremor of Graves's disease, we have never seen any "series" of oscillations, but they exhibit a continuous tracing of fairly regular vibrations, occasionally varying somewhat in amplitude, but with a rhythm of about 10 per second.

Tremor in Graves's disease is one of the early signs. Indeed, Mobius has recorded a very interesting case, in which a woman of fifty was seized, after "painful moral emotions," with a tremor of the left hand resembling paralysis agitans, and this was soon followed by all the signs

[1] *Thèse*, Paris, 1883. All endeavours to procure a copy of this Thesis having failed, I am obliged to give a reference taken from the *Rev. des Sciences Médicales*. Our own observations were conducted quite independently of this, and we were unacquainted with it at the time of performing our experiments.

of Graves's disease.[1] Tremor associated with tachycardia and thyroid enlargement, leaves no doubt as to the diagnosis of the case, and if careful inquiry is instituted many of the minor signs are to be found indicating profound affection of the nervous system. If to these signs marked diminution of the electrical resistance be added, we have a further confirmation.

Liègois diagnosed a case of Graves's disease in a patient with marked tremor, although neither goître nor exophthalmos was present. The patient had paresis of the limbs, gastric troubles, bouliminia, anorexia, and vomiting. Urticaria, pseudo-lipomata, and simple polyuria were present.

The tremor varies from time to time ; some days it is little noticeable, unless carefully looked for, or the patient is fatigued. Fatigue always increases the amplitude of the vibrations, and when the patient's general health is disturbed the tremors increase in intensity.

The observations of myself and Dr. Dawson Williams have shown how little these nervous tremors differ from each other in rate of rhythm, and how little they depart from the tremor of muscle either under fatigue or when thrown into ordinary contraction (8-13 per second), as stated by the researches of Beaunis, Schäfer, Horsley, &c. It is interesting to note that fine tremors were met with in monkeys upon which extirpation of the thyroid gland had been practised by Mr. Victor Horsley.

The Diminution of the Electrical Resistance.—It is well known that if any animal body is put into the circuit derived from a constant current battery, there is an obstacle to the passage of that current, which is termed the electrical resistance of that body to the passage of the current. So far as the human body is concerned, a great deal has been written of "resistance," which we do not propose to criticise now. I may, however, call attention to the following statement, which fairly sums up the question :—"The resistance of the human body," when put forth as a general statement, is a meaningless expression. By it is to be understood chiefly the resistance of the two particular portions of the skin in contact with the electrodes under the conditions of the particular application ; the resistance of the intermediate portion of muscle or other tissues (except bone) being almost negligible in comparison to the former, partly owing to the better conductivity of these tissues, partly to the large, sectional surface they offer to the flow of the current. The resistances of the body will vary not so much according to the distance of the electrodes from one another as according to their diameter, the degree of moisture of the epidermis, its thickness at the point of application, the number of sweat ducts offered to the current, and the state of the cutaneous system, and to a certain degree, with the strength and length of the electrical application. Pressure on the electrodes diminishes the resistance. These considerations help to explain the prodigious discrepancies between the numbers ascribed by various observers to "the resistance of the body." The numbers given in every instance can apply only to the particular parts of the body of the particular individuals tested under particular circumstances ; when, therefore, we read or say that

[1] *Betz's Memorabilien*, Heft 3, 1883.

"2,000 or 3,000 ohms may be assumed to represent the average resistance of the parts of the body when galvanized with medium electrodes according to the polar method adopted in ordinary medical applications, no practical importance, except from the most general point of view, can be attached to statements of this kind, which are used for the purpose of argument and illustration only. Variations ranging between 1,000 and 10,000 ohms are by no means rare under these very conditions."[1]

This statement, while true in a general way, understates the importance of the point. It is quite true that great variations in body-resistance occur, depending on the strength of the current, the size of the electrodes, the moisture or dryness of the skin, and the thickness of the epidermis, and that variations occur in the same patient from time to time; but these variations between one healthy human body and another are comparatively small, and by observing every precaution in the method of examination a fairly constant result may be obtained. Sufficient attention is not given to the point, that conditions of ill health and disease cause this electrical resistance to vary very considerably, and Graves's disease is certainly one of those conditions of the body in which the electrical resistance is remarkably diminished. Charcot and Vigoroux were the first to call attention to this point, but I am unaware that anything more than general statements have been put forward. The point seemed to me worth working out, and having, during the last two years, had a rather extensive experience of Graves's disease in its various forms, I have endeavoured to elucidate this point. Charcot's remarks in the clinical lecture mentioned were as follow :—"The diminution of electrical resistance, inasmuch as it is a symptom at once objective and measurable, is particularly interesting, and may be of great importance in eliminating doubtful cases. If the electrodes of a battery of ten elements are applied, one to the sternum and the other to the back of a healthy subject, a deflection of the galvanometer needle occurs to the extent (say) of thirty degrees; but when the experiment is repeated under the same conditions upon a patient suffering from Basedow's disease, a much greater deflection is found, perhaps up to 90 or 100 degrees. In every case of this disease examined by M. Vigoroux, this condition has been present, and he has also found it in certain cardiac affections, notably asystolism."

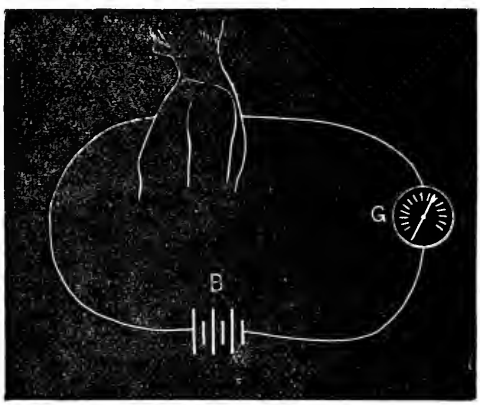
Since electrical methods are not familiar to the bulk of practitioners, and even intelligent physicians who have not given much time and trouble to these questions are ignorant of the "theory and practice" of medical electricity, I shall first describe the mode of estimating the strength of the current used, and the manner of taking the resistance of the body.

It is first to be presumed that the experimenter is in possession of a constant current *battery*, a *galvanometer* which will register the current in milli-ampères, and a *resistance coil* of 1,000 ohms. In addition to these, instead of using sponges, &c., the *standard electrodes* recommended by de Watteville,[2] should be employed, in order to establish

[1] De Watteville: *Medical Electricity*, p. 46. [2] *Loc. cit.*

uniformity in the method of investigation, and lead to a just comparison of results. In order further to obtain this end, the electrodes should always be applied to the same spots, and in all cases I have placed one on the back of the neck, and the other on the top of the sternum.[1]

The strength of current used having been estimated with the galvanometer and resistance coil before passing it through the patient, by placing the coil in the circuit, and reading off the number of milli-ampères on the galvanometer which indicates the current strength in *volts*, the method of taking the resistance is indicated in the following diagram, substituting the patient for the resistance coil :—



The deflection of the galvanometer needle indicates the strength of the current passing through the patient, but *not the resistance of the patient*. This is found by a simple calculation. Supposing a current strength of 15 volts (as estimated by the galvanometer and resistance coil) to be passed through the patient, and the deflection of the galvanometer needle to register 5 milli-ampères, then—

$$\frac{15 \text{ volts}}{5 \text{ m.a.}} \times 1{,}000 = 3{,}000 \text{ ohms}$$

and the resistance of the patient is therefore 3,000 ohms.

Now, if a number of indifferent patients are put in the circuit of a current of 15 volts, it will rarely be found that the galvanometer indicates a deflection of more than 3 or 4 milli-ampères ; in other words, the resistance of the patient ranges between about 4,000 to 5,000 ohms. It seldom happens that the galvanometer needle deflects 5 or 6 milli-ampères, indicating a resistance of from 3,000 to 2,500 ohms, and from experiments made upon a large number of patients with common non-nervous complaints, such as sore throats, tonsillitis, and so on (the ordinary class of patients frequenting a throat hospital), and also upon individuals who may be presumed to be perfectly healthy, I find the body resistance to range normally between 4,000 and 5,000 ohms, and I

[1] All these appliances can be obtained at small cost from Mr. J. B. Thisleton (Electrician to the Throat Hospital, &c.), Old Quebec-street, London.

am accustomed to regard anything under 2,000 ohms as abnormally low, and under 1,000 ohms as remarkably diminished resistance.

I will give illustrations of the point in reference to Graves's disease. There is no need to detail all the cases which I have investigated, but I will give examples of marked, and also of undeveloped Graves's disease, examined by myself, in the presence of, and with the assistance of several American Canadian and other practitioners, who have during the last two years been attending the practice of the Throat Hospital, and to whom I have over and over again demonstrated the point.

CASE I.—A. R., aged forty-nine, a warehouseman's wife, said that her illness dated from three weeks before coming to me. Catamenia had stopped three months before. She presented the fine tremor so characteristic of the disease. The thyroid was bilaterally enlarged, soft, and throbbing. Pulse was 168. Heart acting forcibly, palpitation at times, and cervical vessels giving the characteristic thrill. There was a very slight degree of exophthalmos, and the patient presented the very frightened expression so aptly described by Trousseau, in which the eyes participated. Graefe's lid sign was absent. There was much frontal headache, constant cough, and feeling of faintness and sickness, but no diarrhœa. Sweating of the whole body and a feeling of heat was prominent. The body temperature, taken in the axilla, was 100°. Sleep was restless and bad, and the appetite poor.

The electrical body resistance, estimated with a current strength of 15 volts (10 cells of a Leclanché battery), registered 300 ohms only. Examined again a fortnight later it stood at the same figure, viz., 300 ohms.

Faradic treatment was recommended twice a week (to be mentioned further on), but the patient would not persevere with it after a fortnight, and left the hospital. I have not since seen her.

CASE II.—E. A., aged nineteen, engaged in a shop, stated that the disorder had been coming on for twelve months, at first causing swelling of the right side of the thyroid. Now there was bilateral swelling of the thyroid, soft and throbbing, slight double exophthalmos, clammy skin, and frequent sweats, very fine tremor, no diarrhœa, no palpitation except when going upstairs, and no cough. Catamenia were perfectly regular. Temperature 100$\frac{3}{5}$. Appetite and sleep were good. The same nervous, frightened facial aspect, with twitching of the lids, as in the previous case.

Electrical resistance with electro-motive force of 13 volts, marked only 200 ohms. A fortnight later, with general improvement in health (normal temperature, less tremor, &c.), the electrical resistance had risen to 1,000 ohms.

CASE III.—M. H., aged eighteen, employed as a "feather comber," said that the condition came on twelve months before, with a "swelling in the throat."

Latterly the eyes had become rather prominent. The thyroid was bilaterally enlarged and soft, and the cervical vessels throbbing. Palpitation was complained of at times. Pulse 120. Much fine tremor. Slight proptosis. Catamenia regular. Diarrhœa and sickness coming on in crises. Feeling of dry heat, and frequent sweating. Temperature 99·5.

Sleeps well, but has had frequent spells of insomnia. Much frontal headache and constant cough. The girl was very anæmic, and also complained of slight dysphagia.

Electrical resistance measured 500 ohms.

A month later, under faradic treatment, the thyroid had much diminished in bulk, the general condition was improved, and electrical resistance had increased to 1,000 ohms.

CASE IV.—A. C., aged twenty-two ; bilateral, but not great, thyroid swelling, especially of right lobe ; throbbing. Pulse 124; palpitation ; tremor ; dyspnœa ; spurious angina pectoris ; catamenia regular ; very nervous and excitable, and a bad sleeper. A younger sister is developing Graves's disease. No exophthalmos. Electrical resistance 1,340 ohms.

In all these cases it is observed that the electrical resistance is very low indeed, and even those who might be inclined to think that observations upon body resistances are fallacious, will, however, admit that here are most striking illustrations of the truth of the statement that the electrical resistance is diminished in Graves's disease.

CASE V.—C. P., aged fifty-two, came to me with a bilaterally enlarged thyroid, which was moderately hard, and which, she said, had been getting gradually worse for the last two years. It was pulsatile to palpation. There was exceedingly fine tremor, and a moist clammy skin, with body temperature of 99·6. Palpitation was distressing, and pulse registered 128. There was no dilatation or hypertrophy of the heart, and no murmur. There never had been the slightest proptosis. A right-sided hemicrania was very distressing ; diarrhœa without colic occurred usually after food. Sleep was good, but appetite bad. The catamenia had ceased for two years.

Electrical resistance was 1,200 ohms.

The patient lived away in the country, and was ordered a faradic battery to use herself. I have not seen her since.

It is unnecessary to occupy space with enumeration of other cases. I merely mention these as examples. I have dealt fully with the matter of electrical resistance in a paper published in the *Practitioner*, to which I may refer the reader. Since that paper was published my clinical assistant, Dr. Cecil Shaw, has made observations upon nine fresh cases which have come under my care. He found resistances of 850, 950, 535, 750 625, 1,000, 1,150, 1,700, and 2,000 ohms. In this latter case, the resistance had been 750 ohms, but had mounted up under treatment which improved the patient greatly. This, I may add, is the general rule. As patients improve in health the body resistance reaches a more normal point, and thus, to a certain definite degree, the estimation of the body resistance becomes a valuable index of the amount of improvement.

As to its value as a means of diagnosis, there is no doubt. In ordinary goître the skin resistance is not diminished, and has never in any of my cases been below an average of 2,000 ohms, usually registering 4,000 to 5,000 ohms, or even more. The method may then with safety be applied to the diagnosis of obscure cases of goître with certain nervous phenomena, which do not present typical signs of Graves's disease, a class of case which I have not unfrequently seen wrongly diagnosed and treated for ordinary struma.

Why should this diminution of resistance occur in Graves's disease? It is not due to excessive moisture of the skin, for even with the skin dusted with starch powder and the electrodes almost dry, I have been able to obtain it. It is not due to using different electrodes, for in most cases when I

have tested the body resistances of these patients, I have at the same time tested that of a healthy person; and moreover, I always use the same electrodes, and conduct the experiments under precisely the same conditions. It will scarcely be argued that persons with Graves's disease have thinner epidermis than other people, and it is not due to differences in the electro-motive force of the current, for my habit is to use a current strength of 15 volts, and in many cases, with a current strength of only 2 to 3 volts, one can get a deflection of the galvanometer needle, proving greatly diminished resistance, and this strength of current would make no impression whatever upon the body of a healthy person. The "why and wherefore" is therefore not clear, but the fact is assured. It is possible the diminished resistance may find some explanation in the general vascular dilatation which is the accompaniment of this condition, and in which the skin must participate. There is no disease in which the body resistance is diminished as it is in Graves's disease, as I have endeavoured to show in my clinical experiments before mentioned.[1]

(To be continued.)

NEW INSTRUMENTS AND THERAPEUTICS.

WEIL (Stuttgart).—**A New Palate Hook.** *Monats. für Ohrenheilk.*, 1888, No. 7.

A MODIFICATION of Voltolini's palate hook. **Michael.**

BRINDLEY JAMES, J.—The Pneumatikon. *British Medical Journal*, May 26, 1888.

A "RESPIRATOR INHALER," entirely destitute of novelty,—yet considered worthy of being registered. **Hunter Mackenzie.**

RUSBY, H. H. (New York).—**Cocillana Bark, a proposed New Remedy for Catarrh.** *Therapeut. Gaz.*, August, 1888.

THIS is a new bark discovered by the author in Bolivia. From experiments made by the author it is found to contain a strongly active principle related to emetine, and which is excreted from the respiratory mucous membrane. It would be good in nasal catarrh, acute or chronic, locally applied, or much more securely by internal application. Its use is indicated in membranous croup and the early stages of diphtheria. The drug is closely related to ipecacuanha in its properties as a powerful emeto-cathartic and expectorant. **R. Norris Wolfenden.**

TYRRELL BROOKS, W. (Oxford).—**Notes on Antipyrin.** *British Medical Journal*, May 19, 1888.

AMONGST several complaints in which this drug is stated to have been used with success are certain spasmodic nervous disorders, such as hay fever and whooping-cough. **Hunter Mackenzie.**

[1] *Practitioner*, 1887.

DUTT, U. K. (London).—**Idiosyncrasy with regard to Antipyrin.** *British Medical Journal*, May 26, 1888.

AFTER administration of an antipyrin tabloid, violent itching, tingling, and burning sensations were experienced on the hard and soft palate and in the nose, followed by sneezing. These sensations gradually extended over the whole body. The author thinks that the drug first exalts and then exhausts the functions of the sensory nerves, in the latter way inducing anodyne effect. **Hunter Mackenzie.**

RHYS, GRIFFITHS P. (Cardiff).—**Cocaine in Acute Tonsillitis.** *British Medical Journal*, April 28, 1888.

RECOMMENDS swabbing the throat at intervals with a 4 per cent. solution, and pouring a few drops of the same into the ear.

Hunter Mackenzie.

HOLMES JOY, J. (Tamworth). — **Poisoning by Stramonium.** *British Medical Journal*, April 21, 1888.

AMONGST other symptoms, "the mouth and throat were dry, and the fauces insensible to the touch, so that irritation of the pharynx produced no reflex action." Recovery. **Hunter Mackenzie.**

FERORERS.—Treatment of Whooping-Cough with Quinine, especially by Injections. *Jahrbuch für Kinderheilk.*, Bd. 28, Heft 2.

A RECOMMENDATION of this method, with illustrative cases.

Michael.

TABOADA.—Chronic Catarrh and the Mineral Waters of Alhama de Aragon. *Boletino de Med. y Cirugia*, Madrid, August, 1888.

TABOADA analyses the pathogenesis of the catarrh under all aspects in which it has been considered, and then treats of that which appears in the respiratory tract. He studies, in the first place, the arthritic form in its rheumatic and gouty varieties, and then deals with the herpetic form, in order to expose the hydro-therapeutic treatment by the waters of Alhama de Aragon, which contain, besides carbonic acid and nitrogen, a good deal of antimony and arsenic. Potions of the water, and inhalations in the celebrated natural cascade, which serves at the same time as a vapour bath, are the means used by him, and with which he has obtained very excellent results. **Ramon de la Sota.**

VALENZUELA, FRANCISO.—Recent Respiratory Therapeutics. *Boletin de Med. y Cirugia*, Madrid, August, 1888.

THE author made a communication which was discussed at the National Hydrological Congress, held in Madrid in February, 1888, and stated that his experiments with hydrofluoric acid as an inhalant led him to the following conclusions:—When forty minims of a mixture of one part of hydrofluoric acid in two parts of water are inhaled for one hour, two or three times daily, by a patient with tuberculosis, or catarrh, the first effect produced is cough, which soon ceases, followed by sneezing and great excitation in the throat, which symptoms, however, speedily disappear.

From the first inhalation cough and expectoration diminish, then nearly, or entirely, disappear. Dyspnœa was not improved in emphysematous patients, and the general tubercular process was not arrested in phthisical patients. Hæmoptysis was not modified. By combining hydrofluoric inhalations with suboxygenated air, the author had obtained mitigation of cough, expectoration, and dyspnœa, arrest of the phthisical process and sweats. Inhalations of hypobromous acid produce a sense of warmth in the trachea, and dyspnœa, which disappear in a short time. The expectoration increases during the first few days, afterwards diminishing, and hæmoptysis is satisfactorily arrested. No favourable result was obtained in tubercular patients, or those with broncho-pneumonia, from inhalations of sulphurous acid, sulphuretted hydrogen, or iodoform. Inhalations containing carbolic acid, the balsams, or creosote are useful in bronchial catarrhs with hypersecretion, but are useless in tubercular patients.

Ramon de la Sota.

COMPAIRED.—Value of the Hydro-therapeutic Treatment of Ozæna. *Boletino de Medicina y Cirugia*, Madrid, July, 1888.

AT the first session of the National Hydrological Congress the author read a communication upon this subject, in which he drew the following conclusions:—1st. Ozæna is an exclusively local disease, probably infectious and contagious, and which constantly appears in scrofulous and syphilitic persons, in which cases it is a manifestation of the general process which accompanies it. 2nd. That even when the hydro-therapeutic treatment has been looked upon in ozæna as accessory, he believes that it must give very satisfactory results. 3rd. That the washing is an important process in the treatment, It must be performed scrupulousl and frequently, whether with the Weber's douche and Morra's rhinoclisma, or with Fauvel's douche, or both, and must be followed by inhalations in those establishments in which this balneotherapic process can be used.

Ramon de la Sota.

STOKER, GEORGE.—The Use and Abuse of Local Treatment in Diseases of the Upper Air Passages. *Brit. Med. Jour.*, September 15, 1888.

ONE abuse of local treatment is the insufflation of powders to a larynx in which there is secretion, without first cleansing the surface. Insufflations find their best use in syphilitic laryngitis with ulceration, and in cancer. In the case of granular pharyngitis, the cautery should be applied to the granules, not to the overfull veins surrounding them. The cautery is abused in treating nasal polypi, and enlarged tonsils. Congestion of the pharynx and ozæna are cases in which general treatment is most beneficial, in the former case removing plethora of the digestive tract, in the latter combating anæmia by iron, &c.

R. Norris Wolfenden.

HALL, F. DE HAVILLAND.—The Use and Abuse Local Treatment in Diseases of the Upper Air Passages. *Brit. Med. Jour.*, September 15, 1888.

OBSTRUCTIONS of the respiratory channels call for treatment, *e.g.*, adenoid

vegetations, nasal polypi, hypertrophies of mucous membrane, deflections of the septum. The latter condition has called for much unnecessary interference. Asthma, sneezing, and hay fever are benefited by local treatment of the nose. The neglect of the general physician to look to the naso-pharynx in the course of the exanthemata is unpardonable, leading as it does to otitis media and deafness.

Affections of the posterior wall of the pharynx must be treated by constitutional measures as much as by local. Gout or plethora of the system lead to a granular condition of the pharynx and dilatation of vessels. The liver and stomach should be treated before local measures are adopted. Local treatment is abused in nervous cough. Nothing is so good as a sea voyage. Many cases of laryngitis are due to nasal obstruction. Any local measures in acute laryngitis beyond soothing inhalations are an abuse (?). Physiological rest is the great object to attain.

Malignant growths in the larynx should not receive local treatment. As soon as a diagnosis is made microscopically, the chances of operation should be discussed.

Active local treatment is required in innocent neoplasms.

The author deals with laryngeal phthisis. (We scarcely recognise under the name "M. Ehring," our *confrère* M. Heryng. The paper contains nothing new or original, being merely delivered to open a discussion at the meeting.) **R. Norris Wolfenden.**

DIPHTHERIA.

MARIANI.—Can Two Forms of Diphtheria be distinguished as to Prognosis? *Rev. Medica Vasio-Navarra*, June, 1888.

In a communication read by Mariani to the Congress of Gynecology held in Madrid, he drew the following conclusions :—1st. Diphtheria is a primary general infection with local manifestations which have their place of selection. 2nd. In diphtheria there is a severe, rapid, and fatal form, which neither yields nor modifies itself under any treatment. 3rd. There is a slight attenuated form, if one can call it so, which is curable by several means, and also spontaneously, as some physicians suppose. 4th. The general treatment must be regarded as the principal end of the physician, and in this sense oxalic acid is likely to give excellent results. 5th. The local treatment must be simple, by avoiding, as far as possible, any worrying of the patient with energetic measures or too frequent applications, the uselessness and also the dangers of which are completely acknowledged. **Ramon de la Sota.**

JACUBOWITSCH (St. Petersburg).—**On the Prolonged (or Chronic) Form of Diphtheria, and Perichondritis of the Larynx in Children.** *Archiv. für Kinderheilk.*, Bd. 10, No. 1.

This form of diphtheria is very rare. The author, however, describes some cases which have come under his observation :—

1. A child, one year and three months old, contracted scarlet fever.

Diphtheria of the fauces followed some weeks later, and the diphtheritic membranes remained upon the tonsils and vault of the pharynx for two months. There was also stenotic respiration, which increased. Tracheotomy was performed, and death followed. At the autopsy, perichondritis of the cricoid cartilage was found. The mucous membrane of the pharynx was covered with pus and membranes.

2. A case of chronic perichondritis of the larynx in a child two years of age, caused by burning. Death occurred from scarlatina.

3. A diphtheritic throat, lasting for twenty days, in a child ten years old, followed by asphyxia and death.

4. A child, ten years of age, had diphtheria with especially severe septic symptoms. The diphtheria and adynamia lasted for two months. Convalescence then occurred, and a cure resulted.

5. A child, six years of age, had diphtheria of the tonsils and vault of the pharynx, which lasted for two months, but was eventually cured. The author treated his cases of chronic diphtheria (and also the acute cases) with chloride of iron, mercurial sublimate, and turpentine. **Michael.**

PINIAZEK (Cracow).—**On the Measures to Prevent Secondary Attacks of Suffocation after Tracheotomy for Croup.** *Archiv. für Kinderheilk.*, Bd. 10, No. 1.

THE author's observations are of great interest, since they relate to conditions which commonly end in death. If secondary stenoses occur after tracheotomy, most of the little patients die. The author treats this condition very energetically. He frequently has introduced a tube or speculum through the fistula, through which, by aid of the reflector, he has been able to view the membranes in the trachea, the bifurcations and openings of the bronchi. At first he endeavoured to remove these membranes by introducing a catheter and sucking them out, but he afterwards found that they could be better removed with Schroetter's pincette, or by a special spoon which he had constructed for the purpose. With this instrument he was able to reach as far as the second bronchi. He relates four cases which were saved by this method. With the aid of his speculum he could in one case diagnose a cicatricial ring in the trachea, and in other cases granulations, which were the cause of the stenosis. These cases could be cured by galvano-cautery operations. **Michael.**

BARBIER, TH.—Albuminuria in Diphtheria. *Gaz. des Hôp.*, May 12, 1888.

BIBLIOGRAPHIC review of the question. Excellent work. **Joal.**

CLEMESHA, J. W. (Port Hope, Ont.).—**Tracheotomy in Diphtheria.** *Montreal Medical Journal*, June, 1888.

THE author reports a case in a child of eight years, of severe type. The patient was first seen on March 15. On the 17th laryngeal invasion was evident, and tracheotomy was performed on the 19th. The tracheal wound was subsequently covered with membrane. A spray of lactic acid in lime water and glycerine was used; stimulants were freely administered, and the tube permanently removed on the fifteenth day. The early performance of the operation is urged. **G. W. Major.**

MOUTH, TONSILS, PHARYNX, &c.

SHEPHERD, F. J. (Montreal). — **Glossitis.** *Medico-Chirurgical Society of Montreal*, May 4, 1888.

Dr. Shepherd described a case of hemiglossitis recently under his care. The patient, male, aged thirty, had the glossitis limited to the right half of his tongue. The attack was ushered in with fever and malaise, and the case rapidly recovered. **G. W. Major.**

HUNT (Clarksburg, Ont.). — **Idiopathic Glossitis.** *Transactions Ontario Medical Association*, July, 1888.

In idiopathic glossitis the use of ice in the treatment of the disease was strongly advocated. **G. W. Major.**

HEATH, CHRISTOPHER (London).—**Clinical Lecture on Diseases of the Tongue.** *British Medical Journal*, April 21, 1888.

The lecturer considers diseases of the tongue under three heads—inflammations, ulcerations, and deposits.

Acute glossitis may be idiopathic, but more often it appears to be connected with the administration of mercury. The treatment is simple—an incision on each side of the middle line of the organ.

Chronic inflammation is most commonly due to smoking. The lecturer has no doubt that tobacco has a deleterious effect upon the mucous membrane of the tongue. The surface is *reddened* during the early stage of chronic glossitis (tobacco), and it is only when this has passed away that the whitened condition ("leucoplakia" or "leucoma") is developed. These white patches may be mistaken for epithelioma; they undoubtedly render the individual liable to epithelioma. They may develop into warts, or into ichthyosis, the latter being very closely related to epithelioma.

The syphilitic affections of the tongue involving a chronic change in the epithelium are chancres and mucous tubercles (rare), and the common specific affection—a variety of chronic glossitis with cracks—which is well recognized as the result of secondary disease. The lecturer strongly advises the use of mercury internally and locally, in the latter case subjecting the tongue to the process of "pickling."

Ulcerations are of three forms—syphilitic, tubercular, and epitheliomatous. The syphilitic ulceration may be superficial or deep; the tubercular ulcer is usually situated at the tip of the tongue; the epitheliomatous ulcer "is not simply an ulcer, but an ulcer with a growth, a growth springing up at the edges of the base, and forming a protrusion."

Deposits in the tongue are of two kinds—the epitheliomatous and the gummatous. The former always follows the ulcer, and extends beneath it, whilst the latter is apt to develop in the central portion of the tongue, and give rise to formidable-looking ulceration.

The lecturer does not believe in the efficacy of Chian turpentine or other drugs as a remedy for cancer of the tongue. Early operative treatment alone has any prospect of removing the disease.

Hunter Mackenzie.

CASTELO.—Deep Fissure of the Tongue. *Revista de Medicina y Cirugia Practicas*, Madrid, July 22, 1888.

THE condition was an ulceration situated on the superior surface and right side of the tongue ; its transverse extent was one centimetre, and its length five. It was of cavernous aspect, had flat borders, and, at the level of the rest of the organ, lightly and irregularly crenated, excavated walls, uneven base of grey-yellow and dark colour, with peripheral plastic infiltration. The patient felt great pain in speaking, drinking, and eating. From the pathological antecedents of the parents and brothers of the patient, and by his own, from the form and objective character of the ulcers, the absence of lancinating pains, of neuralgic irradiations, hæmorrhages, or submaxillary enlargements, and from the odour of the secretion, the author diagnosed ulcerated gumma of the tongue. The treatment showed that the diagnosis was exact, the patient being cured with iodide of potassium internally and locally, along with a good hygienic and dietetic treatment. **Ramon de la Sota.**

RUAULT, A.—Contribution to the Pathology of the Fourth Tonsil. *Archives de Laryngol.*, June 15, 1888.

AFTER an anatomical and histological description of the fourth tonsil, called also the lingual tonsil, Ruault studies also the chronic form of pre-epiglottic tonsillitis, which is rather common. Sometimes the mamillated layer has undergone a uniform thickening, and has reached, or even passed, the level of the free edge of the epiglottis, bending this operculum backwards. Sometimes certain groups of follicles only are hypertrophied, and present the appearance of raspberry-like elevations of variable size—sometimes as large as a nut. The region presents a muriform appearance in others, and seems covered with round grains, resembling currants in form. The cause of the affection is little known. The coincidence, more or less marked, of nasal impermeability noted in a certain number of cases, leads Ruault to suspect that breathing with the mouth open may have some part in producing the disease. The symptoms are of a local or reflex origin : feeling as of a foreign body in the throat, suffocative sensation, affection of the voice, cough, dyspnœic attacks, and dyspeptic troubles. Treatment consists in reducing the hypertrophy by cauterization. **Joal.**

LE DENTU.—Neoplasms of the Hyoid Bone. *Soc. de Chir.*, June 13.

THIS was a case in which a tumour developed in a woman aged seventy-one, which was movable in a lateral direction, and presented so great a development that the whole region was invaded. The skin was healthy ; one single gland was enlarged to the right side above the carotid ; the buccal mucous membrane was quite intact ; also the tongue and the salivary glands. No alteration was observed of the pharynx or larynx.

After having performed ablation of this tumour, which was independent of the larynx and easily removed, it was quickly ascertained that it had developed at the expense of the posterior part of the hyoid bone. This was removed at the same time. **Joal.**

VERNEUIL.—Adeno-phlegmon (Sub-hyoidean) and Periostitis of the inferior Maxilla. *Bull. Méd.*, May 2, 1888.

THE differential diagnosis of the two affections is deduced from—

1. The previous history. If the patient has had amygdalitis, periostitis may be eliminated.

2. The objective characteristics of the tumour. In periostitis the greatest degree of tumefaction is on the face; in phlegmon the chin is exempt, and the tumefaction is chiefly situated below the inferior edge of the jaw. The prognosis is different in the two cases. Adeno-phlegmon is rapidly cured; in periostitis prolonged osteo-myelitis must be feared.

Joal.

CHAMPIONNIÈRE, J.—Guttural Reflex observed after Utero-ovarian Operations. *Journ. de Méd.*, Paris, May, 1888.

AFTER operations in the region of the ovaries or uterus, a guttural reflex is often observed, which the author calls "crachotement" (expectoration). Patients have an incessant desire to spit. In bad cases, this insupportable desire incessantly torments the patients, and the effort of spitting is followed by vomiting. In less grave cases this desire, though less frequent, is often very painful. Besides utero-ovarian operations, this spitting is very frequently met with in a marked degree at the commencement of pregnancy. **Joal.**

PONCET, A.—Voluminous Adeno-chondroma of the Palatine Arch. Death from Asphyxia. *Gaz. des Hôp.*, June 14, 1888.

THE case of a man, aged fifty-seven, who had a tumour weighing 150 grammes, and who died some hours after his admission to the hospital. It is rare to find an adenoma of the palatine vault terminate in such an accident. The volume of these tumours generally varies from a nut to a hen's egg. **Joal.**

TRÉLAT.—Ribbon Ligature in Palato-plastic Operations. *Journ. de Ruault*, April 15, 1888.

IT is well known that Dudon has proposed to employ a ribbon, and to include the two flaps in this ribbon, and by this means to draw them near to each other. Trélat says that this method offers no advantage, for the following reasons:—The time taken in the cure is longer, duration of the operation at least as long, and there is no chloroform used.

Joal.

ROUSSEAU.—Contribution to the Study of Acute Infectious Amygdalitis. *Thèse Paris*, 1888.

AFTER dealing with the history and description of these tumours, the author gives the differential diagnosis with acute and cold abscesses,

hæmatoma, hydatid cysts, erectile tumours, and finally publishes an original observation, and summarizes fourteen cases related by other authors. Joal.

DU CASTEL.—Early Syphilitic Angina. *Soc. Méd. des Hôp.*, June 8, 1888.

EARLY syphilitic angina, which generally coincides with the appearance of roseola, is not admitted by all authors. Its existence appears, however, to be indisputable. It commences, as Lasègue has pointed out, on the arch of the palate, and is characterized by hypertrophy of the glands of the palatine mucous membrane, and notable injection of the vessels of this region. The arch of the palate appears to be dotted over with grains of semolina. The mucous membrane then becomes thickened, infiltrated, and œdematous in patches. The evolution of this symptomatological process requires several days. Joal.

JAMISON, ARTHUR (London). **— Hæmorrhagic Pharyngitis.** *British Medical Journal*, April 21, 1888.

THE author states that "the diagnosis of all these cases rests on the fact of the entire absence of lung mischief, and on the microscopical characters of the sputum. The clear portion of the secretion consisted of large squamous epithelium from the mouth, and many small round cells from the entrance to the larynx, and a few pus corpuscles, the yellow portion of pus and fat cells, a few blood corpuscles, and in great abundance the large spheroidal cells from the pharynx. There were no elastic fibres, nor any distinct epithelium from the alveoli or bronchial tubes." In two cases in which tubercle bacilli were looked for, they could not be found. The author is inclined to think the condition is of hepatic origin.

In regard to treatment, he "treated the throat less, the general condition more." He thinks the profession nowadays pays too little attention to the liver.

(We agree with the author in the value he attaches to the microscopical examination of the sputum, and to the advisability of every practitioner making it a part of his routine work. An important defect in the paper is the entire omission of any description of the appearances of the pharynx in these cases. Had the sources of the hæmorrhage been carefully looked for and detected, local treatment (*e.g.*, the galvano-cautery) might have proved more successful.—REP.) Hunter Mackenzie.

KIDD, PERCY.—Hæmorrhages from the Pharynx and Larynx, and other Hæmorrhages that simulate these. *Brit. Med. Journ.*, September 15, 1888.

A TENDENCY exists now to speak frequently of bleeding from the throat. The causes of hæmorrhage from the pharynx and larynx may be general and local. Of the former are diseases characterized by changes in the blood, and possibly in small vessels, *e.g.*, purpura, hæmophilia, leucæmia, pernicious anæmia, &c. The second group comprises ulcerations, *e.g.*, suppuration, traumatism, the so-called hæmorrhagic laryngitis, and perhaps

a varicose or dilated condition of veins. An actual discharge of blood from the pharynx or larynx, such as in diseases of the first group, is quite exceptional. Submucous extravasations are less uncommon. Serious bleeding from local affections of the pharynx or larynx is very uncommon. Dilated veins in the pharynx may possibly streak the saliva or expectoration, but this is not important. Under the term hæmorrhagic laryngitis several conditions are included. Some are instances of purpura or hæmophilia. In these cases there is seldom more than a staining of the secretions. Such cases, in which the hæmorrhage is often submucous, occur oftenest after strain of the voice. The detachment of dry crusts in laryngitis sicca may give rise to slight bleeding.

The causes of serious bleeding from the larynx and pharynx are three in number, viz., ulceration, suppuration, traumatism. Cancerous ulceration is most likely to give rise to bleeding; syphilitic ulcers occasionally perforate vessels of large size. Bleeding from tuberculous ulceration must be very rare. The author's great experience of these cases has not given him a single instance.

Isolated instances occur where persistent blood-spitting has been traced to a bleeding point in the larynx, without obvious disease of the mucous membrane, supposed to be due to rupture of capillary vessels. The pathology of these cases is very obscure. In the great majority of cases in which bleeding is attributed to the throat, the blood comes from below the glottis, nearly always from the lung, less frequently from the nose, gums, or mouth. Most throat hæmorrhages occur in persons with early pulmonary phthisis, and are really from the lung. It is a mistake to conclude that because there are no physical signs in the chest, phthisis must therefore be excluded, and the hæmorrhage be referred to the throat.

Every hæmoptysis must not be attributed to serious disease of the lung.

Bleeding from the nose, especially if occurring during sleep, may be mistaken for pharyngeal or laryngeal hæmorrhage. Epistaxes are much more common in women after puberty. The erectile tissue of the nose is the immediate cause of the bleeding. Bleeding is common in anæmic girls, the blood having oozed from the gums, mouth, &c. Bleeding is obtained in some hysterical girls by wounding. **R. Norris Wolfenden.**

MILLS, T. WESLEY (Montreal).—**Case of Profound Lightning Shock, with Recovery.** *Montreal Medical Journal*, August, 1888.

DR. MILLS observed, among other symptoms, difficulty in getting rid of saliva and excessive secretion of it for some time after the accident. Loss of speech, after consciousness had been regained, he considers points to paralysis of pharynx and adjacent parts. **G. W. Major.**

SCHAEFFER (Bremen).—**The Pharyngeal Bursa and Tonsil.** *Monatss. für Ohrenheilk.*, 1888, No. 8.

THE author concludes a paper upon this subject with the following theses:—

1. The "bursa pharyngea" is in rare cases congenital, or develops later as the result of pathological processes.

2. Most of Tornwaldt's cases are pathological, produced by diseases of the pharyngeal tonsil.

3. There is no reason to call this condition "bursitis."

4. The treatment often gives negative results.

The author then relates cases of disease of the pharyngeal tonsil, and their treatment. In one case he observed a cyst of the bursa as large as an apple, which he removed with Michael's forceps. **Michael.**

MOLLER (Aalborg, Denmark).—**A Case of Pharingotomia Subhyoidea—Recovery.** *Ugeskrift for Laeger*, July 21, 1888.

A GROWTH, consisting of four divisions, each being the size of a small hazel nut (according to the description it seems to have been an adenoma), originating with a broad base from the left edge of the epiglottis, was removed through a five centimetre long transverse incision in the thyro-hyoid space, in a man aged thirty-two, in whom attempts to remove the growth *per vias naturales* had previously failed. The operation was preceded by tracheotomy, and the tracheotomy wound was afterwards sewn up, but the development of a considerable emphysema after the operation forced the operator to re-open the tracheotomy wound. The patient recovered speedily; only a very slight hoarseness was left when he was seen last, about a month after the operation.

Holger Mygind.

MORENO Y DESVERNINE.—Foreign Body in the Gullet· External Œsophagotomy. *Cronica Medico-Quirurg. de la Habana*, June, 1888.

MORENO was called to see a man who was choking through an artificial set of teeth having, during his sleep, fallen into his throat. Being unable to extract the foreign body, Moreno caused it to change its position, with which the patient was relieved. Desvernine saw the case in consultation, and he tried to extract the set of teeth by the mouth, but, not succeeding, eight days after he performed without any accident external œsophagotomy and extracted the foreign body. The patient had some hæmorrhage and was in a critical condition for some days, but a month after the operation there was only a small fistula in the neck. Desvernine reproduces Fisher's statistics upon external œsophagotomy, completing it with the two cases of Sota and the present case. **Ramon de la Sota.**

PLICQUE (Paris).—**Critical Study on the Treatment of Cancerous Strictures of the Œsophagus.** *Ann. des Mal. du Larynx, &c.*, August, 1888.

THE author passes in review four methods of treatment:—

1. *Dilatation by Catheterism.*—This method is both ineffective and dangerous. The results are not permanent; spasm and inflammation are apt to follow the introduction of large sounds, and there are dangers of penetrating the aorta, bronchi, and mediastinum. Non-cancerous strictures are those which benefit most by this method.

2. *Gastrostomy* is less successful in malignant than in ordinary strictures. When the operation is performed late on, mortality is excessive.

Early gastrostomy, so often performed in England, is rarely done in France. Of 145 cases of gastrostomy collected by Lagrange the mean duration of life has only been nineteen days. The operation is useless and unnecessary if performed early, and too late if held over till the condition is advanced.

3. *The Employment of Permanent Catheters* (short and long).—These have remained in the œsophagus five months (Boyer), 305 days (Krishaber), three months, fifty-five days (Kirmisson). Long sounds may produce ulceration at the level of the cricoid cartilage, and they prevent the patient from swallowing directly. Morell Mackenzie tried to overcome this by employing a short sound. Symonds introduced sounds of variable diameters (Nos. 10, 13, and 16), of seventeen centimetres in length. Renvers modified them by making them of soft material, and latterly by employing canulas of horn or caoutchouc in the form of a cone, five centimetres high, twelve to fourteen millimetres at the open, and six to nine millimetres at the narrow part. The canulas are flattened from before backwards, to pass more easily over the region of the cricoid cartilage. The sound is introduced into place by a conducting bougie, and kept in place by threads passed out through the mouth. Liquid alimentation must be employed. Renvers' canula acts as a dilator, and in a few days many patients find they can swallow naturally, though only temporarily. A great point in favour of Renvers' tubes is that patients can satisfy their thirst. Patients can wear their canulas also better than long sounds. Certain cases—when there are broncho-œsophageal perforations—require the use of the long sound. The objection to these short canulas is that the thread to hold them in place has to pass out through the mouth, and is thus insecure. The tubes have slipped into the stomach, but so far have not been shown to do any harm. If the tubes get blocked with food, a fine sound must be passed through them. **R. Norris Wolfenden.**

NOSE AND NASO-PHARYNX.

BOSWORTH, F. H.—The Physiology of the Nose. *Med. News*, August 4, 1888.

THE author maintains the thesis that the functions of the nose are mainly respiratory, the olfactory and phonatory functions being quite secondary, this respiratory function consisting in yielding up to inspired air about 5,000 grains of water, none of which can come from the bronchi or air cells. This water comes by transudation from the blood-vessels underlying the mucous membrane of the turbinated bodies, "the so-called erectile tissue." The physiological proof of Bosworth's ideas (which are founded on clinical observations) is found in Aschenbrandt's and Kayser's experiments, which are quoted by the author at great length. The "erectile tissue" of the nose is designed to subserve serous

transudation and no other function. These bodies are not truly erectile, and have very little to do with the filtering of foreign particles. The author's paper is one of great interest and literary research, and should be read in the original. **Norris Wolfenden.**

HAJEK (Vienna).—**The Bacteria of Acute and Chronic Coryza and Ozæna, and their Relation to these Diseases.** *Berlin. Klin. Woch.*, 1888, No. 33.

A BACILLUS is often found in acute coryza, like Friedlander's bacillus of pneumonia; in chronic coryza the streptococcus pyogenes and staphylococcus pyogenes aureus are often found. In ozæna Friedlander's coccus is sometimes seen, but the bacillus fœtidus is constant and a specific organism. Cultures of this bacillus in gelatine yield the special odour of ozæna. Hajek considers the fœtor of this disease to be caused by the desiccation of the secretion, which, therefore, cannot be removed, and becomes putrescent. **Michael.**

KŒHLER (Posen).—**Two Cases of Rhinoscleroma.** *Monats. für Ohrenheilk.*, 1888, No. 7.

1. A PATIENT, fifty-eight years of age, has the nose occupied by a large tumour with irregular surface. The tumour has slowly grown for twenty-seven years. There is no pain, and all operation is declined.

2. A patient, thirty years old, who has had the tumour for three years. Antisyphilitic treatment was of no avail, but the case was cured by galvano-caustic destruction of the tumour, and for two years there had been no recurrence. **Michael.**

GAUCHER.—**Repeated Epistaxes in a Man suffering from Nephritis.** *Soc. Méd. des Hôp.*, June 22.

OBSERVATION on a man, aged thirty-eight, admitted into the "Hôpital Cochin" for repeated epistaxes, which could only be got under by tamponning the nasal fossæ. A small quantity of albumen was in the urine: there was a slight degree of nephritis. The patient was put upon milk diet, and the epistaxes disappeared. The author concludes that in seeking the cause of an epistaxis an examination of the urine should not be neglected. **Joal.**

OLIVIER.—**A Study of Tertiary Syphilis of the Nose and Nasal Fossæ.** *Thèse Bordeaux*, 1888.

SYPHILIS, at the tertiary period, may produce multiple lesions in the olfactory organs, from simple eruptions, which are situated on the nose, to frightful deformities, which result from disappearance of the osseous and cartilaginous skeleton. These accidents are not common: but the prognosis is always serious, not only from an æsthetic point of view, but even as regards life. Diagnosis is not always easy. When there is any doubt, specific treatment should be resorted to. **Joal.**

BRONNER, A. (Bradford).—**Ozæna: its Nature and Treatment.** *Med. Press and Circ.*, April, 1888.

AFTER some general remarks upon the nature and treatment of this dis-

order, the author relates a case of ozæna arising from empyema o the maxillary sinus, preceded by chronic hypertrophic and atrophic catarrh, accompanied by loss of taste and smell for fifteen years, which was cured by opening the maxillary sinus with Krause's bent trocar on the right side, and on the left side by reaching the sinus by opening from the lower meatus, as recommended by Mickulicz. After the pus was extruded, the sinus was washed out with solution of boric acid and sublimate. Complete cure resulted. A second case of ozæna, related by the author, was caused by suppuration of the sphenoidal cells. The sphenoidal cavity was scraped with a sharp spoon and syringed with boric acid by means of an Eustachian catheter. The ozæna was cured, and smell and taste reappeared. **R. Norris Wolfenden.**

MENOCAL.—Naso-Pharyngeal Fibrous Polypus. *Rev. de Ciencias Medicas*, Habana, March 9, 1888.

A PEASANT had a hard growth, which extruded through the left nasal orifice ; it bled to the least touch, had deformed the nose, impaired respiration, and determined headache and a slight exophthalmos of the left side. Several times the growth was extirpated by torsion and evulsion, and it was reproduced until Dr. Saez performed a radical operation by cutting through the soft tissues, sawing the nasal bones, exposing the growth, and separating it from its basilar insertion with a Volkmann's curette, cauterizing the stump with thermo-cautery, restraining the hæmorrhage with a solution of chloride of zinc (one in ten), and replacing the nose by sutures. The wound healed by first intention, and the patient was discharged, seemingly cured. Two months after, he returned, complaining of the same symptoms. Extirpation of the left superior maxillary bone was performed, all the naso-pharyngeal polypus was extirpated with the curette, and the place of implantation cauterized with thermo-cautery. The wound also healed by first intention, and the cure is believed to be perfect. **Ramon de la Sota.**

SCHROETTER (Vienna).—**On a Peculiar Form of Inflammation of the Nasal Choanæ.** *Monatss. für Ohrenheilk.*, 1888, No. 8.

A PATIENT, twenty-three years of age, acquired an acute coryza. Eight days later he appeared at the clinic. The left side of the nose was normal ; but on the right side there was a tumour filling the nasal cavity, a piece of which was removed. The tumour ulcerated, but the patient was perfectly cured some weeks later. Examination of the tumour proved it to be merely of an inflammatory nature. **Michael.**

LINK (Lemberg).—**Two Cases of Empyema of the Antrum of Highmore, treated by Mickulizc's Operation.** *Wiener Med. Woch.*, 1888, No. 31.

A COMMUNICATION of two cases treated by this method with good results. **Michae**

DOUBRE.—Elephantiasis of the Nose: Radical Cure by Decortication. *Archiv. de Méd. Militaire*, March, 1888.

THE case of a patient treated and cured by decortication of the nose. **Joal.**

LARRAUD.—Recurrent Facial Erysipelas in a Case of Tornwaldt's Angina. *Journ. de Sci. Méd. de Lille*, April 27, 1888.

NOTES of the case of a woman, aged twenty-six, who, from the age of thirteen, had had thirty attacks of facial erysipelas. The malady commenced on each occasion with glandular swelling under the jaw, and by redness round the lachrymal duct. The erysipelas spread from the nose in this case. The patient had Tornwaldt's disease. **Joal.**

WEIL (Stuttgart).—**On Adenoid Vegetations.** *Würtemberg Med. Correspond.*, 1888, No. 27.

AN article reviewing the subject, and recommending Schutze's forceps. **Michael.**

LARYNX.

CHEATHAM, W.—Report on Laryngology. *American Practitioner*, August 18, 1888.

THE subjects reported upon are the local treatment of laryngeal tuberculosis, intubation of the larynx, and partial and total extirpation of the larynx for cancer, and the paper consists nearly entirely of long abstracts quoted from the *Journal of Laryngology* without acknowledgment. This is particularly the case in the report upon extirpation of the larynx, the seven columns of which it is composed being abstracted almost bodily from the *Journal of Laryngology*, without acknowledgment either to that journal or to the author of the articles on extirpation of the larynx.

R. Norris Wolfenden.

AREITZA.—Traumatic Aphasia and Aphonia relieved by Hypnotism. *Correo Medico Castellano*, Salamanca, July 10, 1888.

A MAN received several blows from a stone on the head, and lost consciousness. He recovered it after a few hours, but without being able to speak or to emit a sound. The patient breathed and swallowed well, he understood all that was said to him, and he wrote in his usual manner. After five days without any relief, he was hypnotized by the method of Bernheim. From the second sitting aphonia disappeared; aphasia persisted, however, a longer time. Notwithstanding that from the third sitting he pronounced perfectly all the words suggested, he found some difficulty in pronouncing the others, changing some syllables or omitting others, but in the end he succeeded in speaking correctly.

Ramon de la Sota.

BROWNE, LENNOX (London).—**A Case of Traumatic Perichondritis of the Larynx.** *British Medical Journal*, April 28, 1888.

THE author records this case as an example of a somewhat rare acci-

dent, and as being confirmatory of the fact that caries is not a necessary sequence of perichondrial inflammation. The author further avails himself of this opportunity of repeating the opinion long held by him, that perichondritis may arise quite independently of any of the specific dyscrasia.

Hunter Mackenzie.

MORRIS, HENRY (London).—**Two Cases of Laryngotomy: A Suggestion as to the Applicability of Sutures to the Air Passages in Case of Cut-Throat.** *British Medical Journal*, April 21, 1888.

THE first case was a large recurrent myeloid sarcoma of the face, in which a preliminary laryngotomy, with the insertion of a Hahn's canula, was performed. The growth was then removed, and recovery ensued. The second case was one of papilloma of the larynx, which could not be eradicated by endo-laryngeal means, but which was removed by extra-laryngeal incision. Immediate healing took place after suturing the wound in the larynx.

Hunter Mackenzie.

CASADESUS, ROQUER.—A Case of Impaction of a Pin through the Left Vocal Cord: Extraction per Vias Naturales. *Rev. de Laringologia, Otologia y Rinologia*, Barcelona, July, 1888.

A GIRL, aged six and a half years, was carried to Dr. Casadesus, who discovered with the laryngoscope a pin impacted in the left vocal cord near its ventricular border, with the head downwards. Having applied cocaine the pin was grasped with the lateral forceps of Luer, but on using traction carefully it was impossible to extract it because it was impeded by its head. Repeated trials that and the following day were useless. Forty-eight hours after, the inflamed tissues offered less resistance, and with small effort the pin was dislodged and the patient relieved.

Ramon de la Sota.

SORENSEN (Copenhagen).—**Division of the Posterior Wall of the Trachea by Tracheotomy.** *Ugeskrift for Laeger*, June 9, 1888.

THE author reports five cases of the above accident occurring during the last four years amongst 502 cases of tracheotomy for croup or diphtheria in the Copenhagen Hospital for Infectious Diseases. In the first two cases the true cause of arrested breathing after the introduction of the canula through the laryngeal wound was not discovered until the division was found at the post-mortem examination, having in both cases caused emphysema of the mediastinal tissue and pneumothorax. In the third case the nature of this misfortune was revealed during life, and the canula introduced at last into the trachea. The patient survived the operation eight hours, and at the post-mortem examination was found inflammation of nearly the whole left larynx and pneumothorax of the left side. In the fourth and fifth cases the accident was also diagnosed during the operation, and the canula also introduced at last into the trachea; in one of these cases the patient died four days after the operation, the post-mortem examination not showing any immediate effect of the division of the posterior wall of the trachea, and in the

other case the patient recovered speedily. The author advises passing a feather through the tube to try whether the passage for the canula be free. **Holger Mygind.**

GRASER (Erlangen).—**On Intubation of the Larynx.** *Münchener Med. Woch.*, 1888, No. 38.

THE author has applied O'Dwyer's method in seven cases. In one case of great diphtheritic stenosis, tracheotomy could be replaced by intubation, and the case was cured. In three other cases tracheotomy had to be performed, in spite of intubation, within a short time, but in all cases without effect. In a fifth case the stenosis was increased by intubation, tracheotomy was immediately performed, and membrane removed, and the case was cured. In two cases in which the tracheal canula could not be dispensed with, it could be removed after the introduction of an intubation tube. The author recommends the method for further experiment. **Michael.**

HARVIE, J. B.—**Intubation of the Larynx.** *Montreal Medical Journal*, August, 1888.

THE author has done the operation ten times with two recoveries, seven of his cases dying before the end of the third day. In all the cases the symptoms were most unfavourable. In fifty per cent. there was bronchopneumonia and evidence of pulmonary collapse before the tube was introduced. The relief experienced by the patients was, however, in all cases superior to tracheotomy. He favours feeding by rectum only. The reviewer regrets that he cannot speak as highly of intubation as Dr. Harvie. In cases of diphtheria, when the administration of internal remedies is of first importance, the presence of the tube becomes a source of embarrassment, and even of great danger. **G. W. Major.**

PALMI (Berlin).—**On Tamponading the Trachea.** *Berl. Klin. Woch.*, 1888, Nos. 33, 34.

AFTER having described a method of tamponading the trachea with sponges as "Hahn's tampon canula" (which is really a misunderstood and deteriorated modification of the abstractor's method), the author relates the results of thus treating thirty-eight cases. In most of them the fatal termination was caused by bronchitis, pneumonia, and mediastinitis, thus proving the faults of the method. **Michael.**

MICHAEL (Hamburg).—**On Tamponading the Trachea.** *Berlin Klin. Woch.*, 1888, No. 37.

THE author described the method of performing this two years before Hahn, and claims priority. Hahn's modification, which consists in taking away the gutta-percha cover, is a deterioration of the original method, since the sponge alone does not act as a tampon, but merely as a filter. **Michael.**

CHIARI.—A Case of Tracheal Stenosis, occurring Seven Years after Diphtheria, cured by Tubage. *Ann. des Mal. du Larynx &c.*, July, 1888.

THE author has had occasion to examine many adults tracheotomized during infancy, without finding any laryngeal or tracheal symptom. The case in question was that of a boy of twelve, who, seven years before, had been tracheotomized on account of diphtheria, during which period diphtheritic exudations had occurred in the trachea, with necrosis of cartilages, necessitating the presence of the canula for three weeks. Repeated attacks of bronchitis had followed. Seven years after, he experienced signs of tracheal stenosis, and Chiari found stenosis extending from the third ring of the trachea to two or three rings below. The contraction was caused by cicatrices, caused by loss of substance, leaving a passage large enough for breathing in the child, but not large enough for adult development. Methodical dilatation with elastic catheters, maintained in situ a quarter of an hour, was adopted, and improvement was noted at the end of fifteen days. The treatment was continued until the capacity of the trachea had reached three-quarters of the normal, and respiration was almost free. The tumours noted at the site of the stricture, and which were not only cicatricial tissue, but tumefied mucous membrane also, were rapidly absorbed. The result of the treatment was most satisfactory, the patient being free from signs of stricture fifteen months after. **R. Norris Wolfenden.**

X.—A Pine-Nut in the Trachea. *El Aula Medica*, Valladolid, July 10, 1888.

A GIRL, aged nine years, had two pine cones in her mouth, and suddenly she swallowed them, causing coughing and dyspnœa. With the force of the coughing she dislodged one pine-nut, but the other remained in the respiratory tract for ten days, producing frequent asphyxiative attacks. Tracheotomy was performed. By the force of coughing the foreign body was thrown out and the cure was effected. **Ramon de la Sota.**

NECK, &c.

TRESILIAN, FREDERICK (Mon.).—**A Case of Myxœdema** *British Medical Journal*, April 21, 1888.

IN connection with a case already reported (vide *Journal of Laryngology*, &c., vol. ii. p. 312), the author writes to say that he inadvertently omitted to state the condition of the thyroid gland. As neither the gland nor its isthmus could be felt, it was very probably atrophied.

Hunter Mackenzie.

ZOEGE, MANTEUFFEL (Dorpat).—**Case of Echinococcus of the Thyroid Gland.** *St. Petersburg Med. Woch.*, 1888, No. 30.

A PATIENT, thirty-six years of age, had a tumour of the size of a child's head, situated on the right side of the neck. The tumour was noticed first at twenty-one years of age, as a slight swelling, and was diagnosed as a cystic goître; but operation proved it to be a case of echinococcus. This is the eighth case of the kind on record. **Michael.**

PILLIET.—True Goître and Supra-renal Goître. *Bull. Méd.*, May 2, 1888.

VIRCHOW has related to goître adenoma of the supra-renal capsules, which organs are also blood-vascular glands. In sections prepared from a case, Pilliet found, besides adenoma of the supra-renal bodies, an adenoma of the thyroid gland, that is to say, true goître. **Joal.**

KAHLER.—Nw Symptoms of Graves's Disease. *Prager Med. Woch.*, 1888, Nos. 32, 33.

TWO symptoms which the author has described are tremor and fibrillar contractions of the muscular fibres, and diminution of the electrical resistance. (Symptoms already described by Marie, Charcot, Vigoroux, Norris Wolfenden, and Dawson Williams.) **Michael.**

SMITH, D. T.—Exophthalmic Goître. *Amer. Pract. and News*, September, 1888.

THE notes of a case of a young man of twenty-two, who had hæmorrhage of the lungs, with extensive dilatation of the heart, which beat irregularly and rapidly at 120 to 150; pulse small and compressible. There was no history of rheumatism, and the symptoms of distressing heart-beat after exercise or excitement had first been noticed a few weeks previously. There was no exophthalmos, "though more of the white showed than is the rule with healthy individuals, and there seemed at times an increased pulsation in the arteries of the thyroid, but no pulsation of that body or perceptible enlargement. The author will watch the case and report further developments. [This we shall be interested to learn. It is premature to call the case one of exophthalmic goître yet. Cardiac dilatation and rapidity of pulse are not alone sufficient for this diagnosis; in fact, the heart is not often enlarged in this disorder, as Trousseau pointed out.] **R. Norris Wolfenden.**

SOUZA-LEITE.—Note on a Case of Graves's Disease. Remarkable Improvement under the Influence of Pregnancy. *Progrès Médical*, September 1, 1888.

THE title indicates the nature of the case. All symptoms were much ameliorated during the pregnancy. The author refers to earlier observations of Charcot, Trousseau, &c., on the same subject, and thinks that we may even recommend pregnancy as a therapeutic measure in this condition. **R. Norris Wolfenden.**

REPORTS OF SOCIETIES.

Society of Finnish Physicians.

Meeting, February 18, 1888.

SCHULTEN, M.W., reported a case of *abundant bleeding from the nose* in a lady aged twenty-one, in whom five days previously Schültén had removed some polypi with forceps and cold snare, and who had a quinsy directly after the operation. The posterior plugging, consisting of cotton, soaked in a solution of boric acid, had to be removed fifteen hours after its application on account of its causing fever, dysphagia, pains and noises in the ears, and later on discharge from both ears. The bleeding was repeated several times during the following week, although anterior plugging with iodoform-cotton was used, and the patient made a very slow recovery.

Meeting, March 3, 1888.

PROFESSOR SALTZMANN exhibited a patient with *paresis of the pharynx*, with no history of syphilis or diphtheria. In the course of two months, during which the patient, a man aged forty-four, used inunctions of mercury, he recovered thoroughly. The paresis began with dysphagia and pains in the throat, and he could not swallow anything even on the fourth day after the beginning of the symptoms. The only signs of syphilis were small exostoses on the forehead.

Holger Mygind.

Pathological Society of London.

April 17, 1888.

MR. SHARKEY.—*Alcoholic Paralysis of Phrenic, Pneumogastric, and other Nerves.*

IN specimens from a case it was found that there were slight general inflammatory vascular changes throughout the whole central nervous system. These inflammatory changes were more marked in the case of the peripheral nerves, especially in the phrenic, pneumogastric, and popliteal nerves; corresponding changes had also been observed in the muscles supplied by these nerves.

DR. ORMEROD narrated the case of a child who died suddenly from the pressure of an abscess on one of the pneumogastric nerves. The child was recovering from diphtheria.

DR. G. GRIFFITHS.—*Tumour in Neck invading Jugular Veins.*

SPECIMEN shown and described. The tumour consisted of fibrous tissue, in various stages of degeneration. (This tumour was referred to the Morbid Growths Committee, and was reported to be a "dendritic sarcoma arising from the vessel-walls." The occurrence of growths within veins was rare, and, so far as was known, this case was quite unique.) **Hunter Mackenzie.**

May 15, 1888.

MR. STONHAM.—*Two Specimens of Cancer of Œsophagus necessitating Tracheotomy.*

CARD specimens.

DR. HEBB.—*Cancer of Thyroid Isthmus.*

CARD specimen. **Hunter Mackenzie.**

Clinical Society of London.

April 13, 1888.

MR. R. J. GODLEE.—*A case of Acromegaly.*

IN the case of a lady aged 36, gradual increase of the thyroid accompanied by enlargement of the bones of the face and limbs, especially of the lower jaw and of the hands and feet, had taken place. The cartilages of the ear, and probably of the nose and larynx, were thick and stiff. Hearing was normal, but smell was much impaired, especially for delicate odours. Taste was also much impaired, especially for delicate flavours; the tongue was very thick and large. The voice was harsh, metallic, and monotonous. There was some dyspnœa, partly due, no doubt, to the thyroid enlargement. Mr. Godlee referred to (1) the connection between this remarkable condition of the bones and the abnormal state of the thyroid, comparing it with cases of serous malignant tumours of the thyroid, which had a tendency to recur in bones. (2.) The relation between the abnormal state of the thyroid and the early stoppage of the catamenia. (3.) The resemblances and differences between acromegaly and osteitis deformans. (4.) The superficial resemblance but wide difference between acromegaly and myxœdema.

DR. HADDEN and MR. BALLANCE.—*A Case of Acromegaly.*

A CASE was described, to which attention had first been called three years previously. The appearances present were somewhat similar to those in Mr. Godlee's case, with the exception that the thyroid gland was atrophied.

This disease receives its name from the characteristic enlargement of the hands and feet; the bones of the face also become hypertrophied, as also the cartilages of the nose, ears, and eyelids. The long bones, unlike in osteitis deformans, usually remain unaffected. The thyroid gland has always seemed to be abnormal.

Dr. WILKS, after narrating a case which had been under his observation, remarked upon the possibility of acromegaly being associated with the pituitary body, which had a structural resemblance to the adrenals and the thyroid.

Mr. GODLEE mentioned that fifteen examples of the disease had now been recorded. **Hunter Mackenzie.**

May 11, 1888.

DR. DE HAVILAND HALL.—*Acute Parenchymatous Tonsillitis, or Quinsy, treated by Cocaine.*

NOTES of three cases were read. The author remarked that cocaine had a twofold action in these cases: it diminished the sensibility of the parts, and lessened the blood supply. Deglutition was therefore rendered easier. He further believed that it checked suppuration. He believed it acted more efficaciously after the application of an alkali.

Dr. SEMON believed that cocaine was occasionally used too freely. He had seen the aphagia of tonsillitis relieved by it.

Dr. HALL had seen the use of a spray of a 20 per cent. solution followed by untoward symptoms. He now invariably used a brush. The drug was of use in the parenchymatous variety of tonsillitis only.

DR. PERCY KIDD.—*Complete Bilateral Paralysis of the Vocal Cords, the Result of Acute Laryngitis; Recovery.*

THE absence of mobility of the vocal cords was attributed to paralysis of the muscles from inflammatory infiltration.

Dr. SEMON said this was the first case on record of bilateral rheumatic paralysis of the vocal cords.

Mr. NUNN.—*Necrosis of the Greater Cornu of the Hyoid Bone, and of Ossified Portions of the Thyroid Cartilage; Extrusion of Sequestra from an Abscess in the Anterior Triangle of the Neck, following Gummatous Ulceration of the Tongue, and Perichondritis of Thyroid and Cricoid Cartilages: Profuse Hæmorrhage: Pneumonia: Phthisis.*

THE lengthy title indicates the nature of the case. **Hunter Mackenzie.**

Brighton and Sussex Medico-Chirurgical Society.

April 5, 1888.

Mr. CRESSWELL BABER.—*Adenoid Vegetations of the Naso-Pharynx.*

EXHIBITION of photographs of a man before and after operation.

Mr. R. SANDERSON.—*The Principles and Practice of the Local Treatment of Diphtheria.*

RECOMMENDS the use of a solvent (Finkler's Papain), and afterwards of a germicide (glyc. acidi. carbol, ℥ī. acid to ℥ī. glycerine). The brief discussion which ensued elicited nothing of importance. **Hunter Mackenzie.**

Pathological Society of Manchester.

April 28, 1888.

Mr. JONES.—*Malignant Disease of Jaws.*

A NARRATION of three cases, with exhibition of specimens.

Hunter Mackenzie.

Leeds and West Riding Medico-Chirurgical Society.

April 6, 1888.

Dr. BARRS.—*Myxœdema.*

EXHIBITION of three cases.

May 4, 1888.

Dr. BENDELACK HEWETSON.—*Rhinolith.*

EXHIBITION of a large specimen "of twenty-four years' growth," removed by crushing. Weight, 96 grains. **Hunter Mackenzie.**

Medical Society of London.

April 30, 1888.

Mr. BOWREMAN JESSETT.—*Tracheotomy for Syphilitic Disease of the Larynx.*

EXHIBITION of man, on whom the operation had been performed five years previously. Subsequently a large quantity of papillomatous growths had been scraped away, since which time the voice had returned, and continued good.

Sir WILLIAM MACCORMAC asked what had been done to prevent blood trickling into the trachea.

Mr. JESSETT said tampons had been used. **Hunter Mackenzie.**

South East Hants Medical Society.

April 18, 1888.

Dr. WARD COUSINS.—*Chronic Phthisis with Atlanto-axoid Disease.*

SPECIMEN exhibited. The secondary disease of the cervical spine was stated to be the result of purulent infection (pulmonary).

Dr. F. J. DRIVER.—*Sections of Lung and Trachea affected with Chronic Syphilitic Induration.*

EXHIBITION of microscopical preparations. **Hunter Mackenzie.**

Royal Medical and Chirurgical Society.

May 12, 1888.

Dr. C. THEODORE WILLIAMS.—*On the Results of the Treatment of Pulmonary Consumption by Residence at High Altitudes.*

IN reply to a question, the author stated that laryngeal phthisis was not benefited by treatment at high altitudes.

May 22, 1888.

Dr. PERCY KIDD and Mr. H. H. TAYLOR.—*On the Value of the Tubercle Bacillus in Clinical Diagnosis.*

THIS paper emphasizes the value of sputa-examinations, especially in cases where a positive diagnosis could not be otherwise arrived at. The writers, as well as others who took part in the discussion which followed, considered the bacillary test particularly valuable in the diagnosis of laryngeal phthisis.

Hunter Mackenzie.

Hunterian Society.

April 25, 1888.

Dr. DUNDAS GRANT.—*Laryngeal Cancer.*

THIS case illustrated the unquestionable benefit frequently resulting from tracheotomy in intrinsic epithelioma of the larynx.

Dr. DUNDAS GRANT.—*Nasal Trephine.*

EXHIBITION of instrument. **Hunter Mackenzie.**

Manchester Medical Society.

May 2, 1888.

Dr. THOMAS HARRIS.—*Complete Destruction of Tongue.*

EXHIBITION of a boy, aged fourteen, in whom this had taken place. The ulceration had commenced eight years previously in the soft palate, which had been destroyed. Two years ago an ulcer had appeared in the centre of the tongue, and had subsequently spread over the whole organ. He could not distinguish quinine or common salt. No other evidence of a syphilitic taint was present; but a brother, about twelve months younger, exhibited well-marked signs of congenital syphilis. **Hunter Mackenzie.**

Metropolitan Counties Branch; Western District; British Medical Association.

May 16, 1888.

Mr. BUTHIE.—*Chronic Ulcer of the Tongue.*

NOTES of three cases, which had existed from one and a half to three or four years,

and which had been removed by deep incisions into the substance of the tongue, after failure by scraping and freshening the edges. **Hunter Mackenzie.**

British Medical Association. South Indian (Madras) Branch.

January 13, 1887.

Surgeon F. CLARENCE SMITH.—*Excision of Tongue.*

A REPORT of two cases in which the tongue had been excised by Syme's method, a preliminary ligature having been performed to control hæmorrhage, as suggested by Mr. Jordan Lloyd. **Hunter Mackenzie.**

Clinical Society of Manchester.

March 20, 1888.

Dr. SIMPSON.—*Laryngeal Growths.*

EXHIBITION of two patients—one with papillomatous growths attached to the anterior third of the left vocal cord, and another with two fleshy-looking lobes or flaps springing from the ventricular bands, and overlapping each other in the middle line. In the first case the growths had been several times almost completely removed with forceps, but had recurred, notwithstanding the application of strong astringents and chromic acid. In the second case no operative procedure had been undertaken, but their removal was contemplated by endo-laryngeal means. **Hunter Mackenzie.**

Medico-Chirurgical Society of Montreal.

April 6, 1888.

DR. LAPTHORN SMITH reported a case of foreign body in the nose. The patient, aged fourteen years, had suffered from an offensive discharge for eleven years. On the removal of the foreign body—a boot button encrusted with phosphates—the unpleasant symptoms quickly disappeared. **G. W. Major.**

REVIEWS.

On Cancer of the Larynx. By Dr. BARATOUX.[1]

THIS is a short but concise essay on the subject by this well-known specialist. The history, pathological anatomy, etiology, symptoms, diagnosis, and treatment of the condition are dealt with in successive sections. With regard to total extirpation of the larynx, the author presents results which agree with those published in this Journal (*vide* December, 1887, and January, 1888). He relates 106 cases of total extirpation on account of cancer, and gives the following statistics:—Sixteen per cent. of deaths from the operation, 20 per cent. of those not dying under the actual operation died within the first three weeks from pulmonary mischief, and the total mortality is 52·8 per cent., without calculating recurrences. Of those patients who survived past the twelfth month after the operation, there

[1] Du Cancer du Larynx. Paris, *Bureau du Progrès Médical, or Lecrosnier et Babé*, 1888.

were only nine, that is 8·5 per cent. In face of these statistics, we confess to surprise at finding the author, in the concluding words of his thesis, remark that "the best means of obtaining a favourable result is extirpation of the larynx, especially if the diagnosis of the tumour has been made early, for not only is the life of the patient prolonged, but it is rendered supportable." These are conclusions which we venture to differ from *in toto*, and are glad to find that the author quotes the eminent French surgeons, Tillaux, Verneuil, and Richet, as of the same opinion. Apart from Dr. Baratoux's conclusions, the essay is well written, and will repay perusal.

The Illustrated Medical News.

WE have just received a specimen copy of this new publication. It is of quite novel character, the object of the paper, which we learn is to appear weekly, being to "fill a void in the pictorial representation of clinical and pathological work that has long been felt." *Illustration* is meant to be a principal aim of the paper, which thus differs in its object from all other medical journals. To judge from this first number, the standard of the paper is a very high one, and we hope it will be maintained. There is no doubt a place for such a publication in medical literature, and it should be of great advantage to the average reader of such literature to possess such a paper as this, in which the notable features of each case are set out by means of original drawings, rendering lucid clinical descriptions which are often otherwise tedious and uninteresting. Even very interesting cases are often rendered almost unintelligible when unaccompanied with illustration, and the primary object of this paper is therefore a very useful one. The manner in which the paper is got up, and the illustrations executed (in this first number), is most excellent, and we cordially congratulate the promoters of the journal upon their enterprise, and wish it success.

NEW PREPARATIONS.

STRETTON WATERS.

It is frequently a matter of complaint that most of the artificial mineral waters supplied to the public are of an inferior quality, and this is no doubt true of many of them. These leave an unpleasant taste in the mouth after deglutition, the soda water being more suggestive of sour milk, the ginger beer of burnt treacle, the lemonade of vinegar, &c. Many of the cheaper mineral waters are especially bad in these respects. We have pleasure in recommending the mineral waters of the Stretton Hills Mineral Water Company, of Church Stretton. These are soda, seltzer, potass, lithia, quinine, lemonade, lime juice, ginger ale, ginger beer, &c., and they have been certified to be especially pure by competent analysts. These waters will compare with the best in the market.

VAPOUR CONES AND CASES.

The Chemical Carbon Company have succeeded in producing an entirely novel and most ingenious system of dry inhalation. We have seen nothing yet so perfectly adapted to the purpose. A carbon cone contains a glass flask, in which is placed the medicament to be inhaled. The cone is placed upon a dish with a little water,

after the manner of a Child's night-light, the top of the cone is lighted, and as it slowly burns a heat is generated sufficient to vaporise the fluid in the flask, which is emitted as a dry vapour. No smoke is given off, and the whole process is clean and effective. The Company manufacture a great number of such inhalations, and are prepared to make cones containing any medicament or combination of medicaments desired. In fact, their patent and specialty consists in the manufacture of the cones, the drugs introduced into the flasks being the ordinary medical productions, which can be varied according to the suggestion of the physician. We have seen nothing as yet which can compare with these cones in the production of a dry, clean medicated vapour. The old method of volatilising calomel, for instance, which is so objectionable, is rendered easy and effective by these cones. Terebene, eucalyptus, thymol, pinol, chloride of ammonium, stramonium, creosote, carbolic acid, menthol, calomel, &c., are only some of the inhalations which can be administered by this method. As inhalations are so extensively used in various throat complaints, these cones should be of the highest use for the purpose. One great advantage is their great portability, and another their cheapness. We have no hesitation in most highly recommending the vapour cones in preference to all other methods for the production of dry inhalations. We understand that the Company has overcome the difficulty of producing moist inhalations with the cones, and this can now be accomplished. Large cones are also made for disinfecting rooms and wards, or for charging such spaces with medicated vapours.

NOTES.

Roaring and its Surgical Treatment.—For some time the subject of the treatment of roaring by operation has been discussed, but it cannot at this moment be said that any conclusion has been arrived at; in fact, the matter is still, and for some time to come is likely to remain, in the experimental state. Roaring is by consent among veterinarians used to express an abnormal sound in the breathing, which is observed when a horse is moving quickly—generally a canter or gallop is necessary to the production of the noise; it is only in rare cases that it can be heard in the trot, and more rarely still is any unnatural sound in the breathing heard in the walk, unless the horse is suffering from acute disease of the breathing organs.

Roaring includes sounds of various degrees of pitch and intensity, and there are other sounds, known as whistling, wheezing, and piping, all of them depending on some obstruction in the breathing tubes, the nature of which may be guessed at in many cases, but cannot be ascertained with certainty during life. This fact must be taken into account by those who expect much from the operation which has lately been brought into prominence by Dr. Fleming and others.

It will perhaps be proved in the future that one cause of roaring, and the most common one, it would seem is capable of surgical treatment. Should this probability become a fact, roaring, which depends on disease of one of the muscles (cricoarytenoideus posticus on the left side), may be estimated as a curable disease. But, obviously roaring which depends on other causes cannot be so treated with any prospect of success.

The above remarks will serve to preface a notice or analysis of a remarkable

paper on roaring" by R. H. Clarke, M.A., M.B. Cantab., in the *Naval and Military Magazine* for August.

In the beginning of the paper Mr. Clarke remarks that he had not intended to publish, at their present stage, the results of the experiments which he commenced, at first in conjunction with Professor Horsley, at the Brown Institution in May, 1887, but circumstances have arisen which render their publication desirable. For the purpose of making the experiments intelligible, the pathology of that form of roaring which is due to paralysis of the left abductor muscle which opens the glottis, "the doorway which admits air to the lungs," is referred to; the disease is presumed to be connected with derangement of the recurrent nerves which proceed to the larynx, and during their course are subjected to various degrees of pressure. The left nerve, passing between the heart and the aorta, is especially exposed to pressure when those organs are affected with hypertrophy—a condition which the author has found to exist more or less in all the cases of roaring which he has had an opportunity of examining. This explanation of the constant limitation of the disease to the muscles of the left side is at any rate consistent.

In defining the principles of treatment of roaring, the author of the paper points out that, as the doorway of the lungs is closed, or partly closed, and the paralysed muscles have lost the power to open it, the question of relief resolves itself into the mechanical one of either fixing the depressed cartilage back, or taking it away, so as to leave the door open.

An alternative plan of treatment, by making an opening below the partially closed larynx and inserting a tube (tracheotomy), has long been in use; but those who have had experience of this plan are well aware of the many difficulties and objections which are incidental to its adoption.

Dr. Fleming's operation, as we explained in a recent article, is a novel one only as to its method. Cutting away the whole of the arytenoid cartilage was practised long ago on the Continent with some degree of success, but the operation was performed by cutting a long slit in the windpipe below the larynx, and the healing was often attended with considerable distortion, and the large open space in the larynx allowed the entrance of food. Dr. Fleming operates by a small incision at the bottom of the larynx in the thyroid ligament, and he only cuts away the cartilage and the vocal cord in the left side as far as the ventricle at the back of the cord.

Some of the operations performed by Mr. Clarke are of a more formidable character than the mere section of the cartilage through the windpipe or larynx. He has dissected down to the larynx from the outside, and in his manipulation he uses an electric lamp about the size of the top of the little finger, introducing it into the larynx through a rectangular tracheotomy tube, which is inserted as a preliminary step in the operation—a practice which the author advocates in all cases.

In the first experiment which was made, the larynx was opened in the middle, the left vocal cord was divided, the arytenoid ligament severed, and the fleshy mass of mucous membrane inclosing the left cartilage of Santorini excised. The next experiment was the removal of the whole of the arytenoid cartilage by exposing the left side of the larynx, and then dissecting the cartilage away from the mucous membrane—an operation which certainly requires great delicacy of touch. The operation appears to have been quite successful. One of the horses treated was a bad roarer, and the operator says that he thinks the horse after the operation would have passed sound. The animals were all kept for five months.

Two operations on roarers were successful for the three and a half months during which the animals were kept alive. In one the half of the arytenoid cartilage was removed by lateral incision, and in the other the cartilage was disarticulated, and

fixed in a position of abduction. Both operations require extensive dissections. First, the tracheotomy tube is inserted, then incisions have to be made in two directions, so as to enable the operator to turn back a triangular flap of skin, and expose the parts beneath. The jugular vein is tied at each end of the wound, and the intermediate portion cut away. The fascia is torn through, avoiding injury to the parotid duct and gland, and the side of the larynx is completely bared to view. Arteries and nerves have next to be cut, cartilages to be disarticulated, and the muscles dissected off; and finally the arytenoid cartilage, after being separated from its connection with other cartilages, is carefully peeled off the mucous membrane to which it is attached. The wound is sponged with some antiseptic solution, and the severed parts are properly adjusted by the aid of sutures, and the wound is left to heal.

Experiments for the operative treatment of roaring have now gone far enough to justify the performance of the several operations which have proved, for a time at least, successful on some roarers whose lives are worth preserving.—*The Field*, September 29, 1888.

The British Laryngological and Rhinological Association.

THE next general meeting will be held in London on November 14. Fellows are requested to give early notice of any paper to be read, or communication to be made by them, to the Hon. Secretary, Mr. George Stoker, 14, Hertford-street, Mayfair, London, W.

To ensure the early insertion of abstracts, Authors are requested to *send a copy of any journal* which may contain a contribution on disease of the throat or nose, or on cognate affections, to the EDITORS, *Journal of Laryngology*, c/o Messrs Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Afin de s'assurer une prompte insertion de leurs extraits, les auteurs sont priés *d'envoyer un numéro de tout journal* contenant un article quelconque sur les maladies de la gorge ou du nez et sur les affections qui y ont rapport, aux REDACTEURS du *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W.

Um die rechtzeitige Veröffentlichung von Auszügen zu sichern, werden die Verfasser gebeten, eine Kopie von allen Zeitschriften, die einen Beitrag über Krankheiten des Kehlkopfes, der Nase u. s. w. enthalten, an die HERAUSGEBER des *Journal of Laryngology*, c/o Messrs. Anderson & Co., 14, Cockspur Street, Charing Cross, S.W., zu senden.

London: Paraon & Sons, Printers, Wine Office Court, Fleet Street. E.C.

CONTENTS.

Original Articles, p. 391.—Syphilis of Larynx, Trachea, and Bronchi, by DR. SOLIS COHEN. On Atrophic Coryza (Essential Ozæna), by DR. E. J. MOURE.

New Instruments and Therapeutics, p. 407.—MAYER & MELTZER: Laryngeal Forceps. JAHR: Inhalation Apparatus. GOTTSTEIN: Reply to Dr. Brockmann. CAW: Athmoscope. REICHERT: Camphoric Acid. WATSON: Respirator. MCCLELLAN: External Inflammation of Upper Air-Passages. ALBITSKI: Phthisis Treated by Aniline Method. SHEPHERD: Phthisis a Disease of the Night. BRADDON: Oil of Peppermint as an Antiseptic. ADDINSELL: Cocaine.

Diphtheria, p. 409.—HAMILTON: Non-identity of Diphtheria with Membranous Croup. JACOBI: Nature and Treatment. LANCET: Diphtheria. HOPE: Clinical Features of Diphtheria, and Peroxide of Hydrogen. RIDGE: Naso-Laryngeal Intubation. PARKER: Surgical Treatment. GAY: Tracheotomy and Intubation in Croup. MICHAEL: Diphtheritic Stenosis. THORNTON: Treatment. BRUCE: Papoid and Veratrum Viride. CHOLEWA: Menthol in Diphtheria of Nose.

Mouth, Tonsils, Pharynx, etc., p. 415.—STEWART: Case of Syphilis. FRANKEL, E.: Aphthous Stomatitis. MAXWELL: Resorcin in Ulceration of Tongue. POTTER: Tuberculosis. SCATLIFF: Night Terrors. CAGRIN: Gangrenous Tonsillitis. ALLEN: Gouty Sore Throat. HEWISH: Acute Infectious Pharyngitis. PELTESOHN: Empyema of Frontal Sinus. BEHAGG: Pharyngeal Catarrh. KNIL: Œsophagotomy. PAINTER: Œsophageal Stricture.

Nose and Naso-Pharynx, p. 419.—POTTER: Congenital Bony Occlusion. ZIEM: Narrowing of Visual Area in Diseases of Nose. FOX: Nasal Catarrh and Aprosexia. PEEBLES: Foreign Bodies in Ear. DOWNIE: Aural Reflexes. FENGER: Osteoma. BUCK: Reflexes in Naso-Pharyngeal Catarrh. L., H.A.: Hay Fever. ARNOLD: Hairy Polypi. CHOLEWA: Hypertrophies of Turbinateds.

Larynx, p. 421.—SOLIS COHEN: Cantatory Paresis. MERRIGAN: Erysipelas. HOLLINGSHEAD: Perichondritis. HUTCHINSON *Ibid.* WINSLOW. Cut Throat. BARENDT: Fracture. HOPMANN: Warty Growths. WISE: Laryngotomy for Stenosis. DENTU: Ablation. GARDNER: Total Extirpation. THORNTON: Tracheotomy Tubes. ZALESKI: *Ibid* KIDD: Tracheotomy in Laryngeal Phthisis. WRIGHT: Obstruction to Respiration. GRABOWER: Phthisis. HUMRICHOUSE: Intubation. THOMAS: *Ibid.* CHAMBERS: *Ibid.* CURTIS: *Ibid.* HAWKINS: Foreign Bodies in Trachea. KILNER: *Ibid.* in Bronchi.

Neck, p. 426.—OZENNE: Treatment of Tumours of Thyroid. WHITEHEAD: Surgery of Thyroid. WEBSTER and RULE: Congenital Goitre. WORTHINGTON: *Ibid.* KIRK: Tetanic Spasms in Cretinoid. DECRESSAC: Hydatid Cyst of Thyroid. TERRILLON: Goitre and Interglandular Enucleation. TAYLOR: Graves's Disease. ROCKWELL: *Ibid.*

Societies, p. 429.—American Rhinological Association. Congress of American Physicians and Surgeons. American Surgical Association.

Therapeutic Notes, p. 432.

New Preparations, p. 433.—Jeyes' Sanitary Compounds. Armbrecht's Coca Wine. Boehm's Sozoiodol.

Note, p. 433.—British Laryngological Association.

The Throat & Voice.

Chlorate of Potash Tabloids.

FOR AFFECTIONS OF THE VOICE, THROAT, AND RESPIRATORY SURFACES GENERALLY.

By using these Tabloids the drug is effectually brought in contact with the oral mucous surfaces as a continuous gargle, and its specific action made certain. In acute sore throat, Chlorate of Potash "usually relieves the uneasiness in a few hours" (Cohen). "It is used in ulcerated mouth and follicular pharyngitis, and has been employed in croup, diphtheria, and spasm of the larynx" (Brunton).



Retail price, 6d.

"Of convenient size, they are beautifully made; and, as they dissolve slowly in the mouth, are well suited for throat affections."—The LANCET.

Supplied to the Medical Profession in beautifully graven white metal boxes, blue silk label, at 4s. and 8s. 6d. per doz. Retail, 6d. and 1s. each.

Chloride of Ammonium Tabloids.

The solvent and discutient as well as antiphlogistic powers of Chloride of Ammonium are well known, and have led to its extensive employment, especially in Germany, in cases of sore throat and bronchitis, attended with abundant secretion of thick and tough mucous or phlegm. Physicians will at once appreciate the great advantage to their patients of the local effects of this salt slowly dissolving and coming in direct contact with the inflamed surface. It at once mitigates the cough or irritation, and lessens expectoration. Two or three of the Tabloids will sometimes entirely relieve coughs that have long resisted treatment with ordinary remedies. One may be dissolved occasionally on the middle of the tongue, not near the tip.

Supplied to the Medical Profession in bottles, at 4s. 6d. and 12s. 6d. per doz. Retail, 6d. and 1s. 6d. each.

Sal Prunella Tabloids.

"A popular remedy, sometimes successful in mild cases of incipient inflammatory sore throat, is a small piece of nitre allowed to dissolve slowly in the mouth" (Waring). An excellent saline for throat cases, having very marked local efficacy when slowly dissolved on the tongue. It is a popular remedy, and for mild inflamed sore throat its ancient reputation is deserved.

Directions.—One or more (5 gr.) Tabloids should be dissolved slowly in the mouth for the local effect.

Supplied to the Medical Profession in bottles of 100, at 14s. per doz. Retail, 1s. 6d. each.

Tabloids of Compressed Chlorate of Potash with Borax.

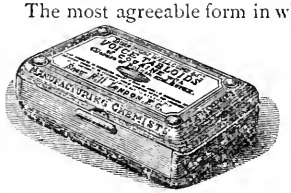
The Tabloids afford an agreeable form in which to prescribe Chlorate of Potash and Borax.

Supplied to the Medical Profession in beautifully graven white metal boxes, pink silk label, at 4s. and 8s. 6d. per doz. Retail, 6d. and 1s. each.

Voice Tabloids.

Voice Tabloids contain COCAINE, CHLORATE OF POTASH, AND BORAX.

The most agreeable form in which to administer Cocaine is in the Voice Tabloids with Chlorate of Potash and Borax. These Tabloids clear the voice and impart to it a silvery tone.

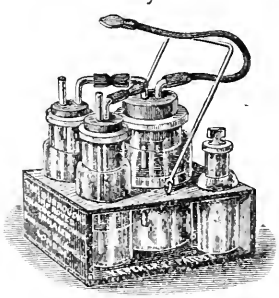


The Voice Tabloids supplied to the Medical Profession in beautifully graven white metal boxes, blue silk label, at 8s. and 16s. per doz. Retail, 1s. and 2s. each.

Chloride of Ammonium Inhaler.

(VEREKER'S PATENT.)

"The vapour of Chloride of Ammonium removes unhealthy and offensive secretions, and restores the long diseased or weakened nasal and respiratory mucous membrane to a healthy state, so that in cases of catarrh, where thickening, induration and irritation exist, a most decided improvement is brought about in a short time." In "throat-cough," pharyngeal irritation, and relaxation and weakness of the throat, it acts as a most effective alterative and tonic to the mucous membrane.



The Burroughs Chloride of Ammonium Inhaler affords perfectly neutral fumes, and is always ready for use.

Dr. FRANKS, Dublin University, says:—"It is the best I have ever used, and I think I have tried all."

Dr. SMYLY, Ex-Pres. Royal College of Surgeons, Ireland, says:—"It is the best Inhaler for Chloride of Ammonium I have met with."

Supplied to the Medical Profession at 7s. 6d. each. Retail, 10s. each.

Supplied by all Chemists throughout the world.

BURROUGHS, WELLCOME, & CO., Snow Hill Buildings, LONDON, E.C.

THE
JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. NOVEMBER, 1888. NO. 11.

Contributors of original articles receive Fifty Reprints gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

SYPHILIS OF THE LARYNX, TRACHEA, AND BRONCHI.

By J. SOLIS-COHEN, M.D.[1]

SYPHILITIC processes are among the most important morbid processes affecting the larynx and trachea. Not only do they injure the structural integrity of the organs directly, but, by their location in the regions occupied by the origin and course of nerve supply, they lead to denutrition of the tissues generally, and to serious motor impairments of the muscles of the larynx. So varied are the manifestations of syphilis, and so important to the welfare of the patient is their timely recognition, that considerable detail is proper in their elucidation. In hardly any other department of living pathology has the laryngoscope been of more signal service than in dispelling obscurities in the conception and comprehension of syphilitic disease of the larynx.

The distinctions between secondary and tertiary syphilis, as manifested in the upper air-passages, are so irregular and uncertain that many writers prefer the terms recent and tardy. In fact, however, secondary lesions are sometimes tardy, and tertiary lesions sometimes precocious Secondary lesions are sometimes present as the sole manifestation of that period. Sometimes they precede cutaneous manifestations. Most frequently they occur in subjects already affected with what are known as mucous patches in other portions of mucous membrane or with early cutaneous syphilides.

Pathology.—The earliest and far most frequent manifestations are subacute, and diffusely hyperæmic conditions of portions of the mucous membrane of varied extent and intensity, an erythema with turgescence, but without supersecretion, occurring within from six to ten weeks after infection. The affected surface exhibits at first the usual rose-colour of congestion ; but, as stases, infiltrations, and hæmic transudations occur, it becomes more or less livid in patches, which present mottled or flaky discolorations. Superficial erosions often ensue. Occasionally deep-seated ulceration occurs. Sometimes paresis of the muscles of the larynx is produced. The erosions may be due simply to denutrition of epithelium

[1] A Paper read before the Philadelphia County Medical Society, September 12, 1888.

from mere pressure by infiltrations, or to disintegration of a characteristic proliferative lesion, known as the papule or mucous patch, by some termed broad condyloma, a product, according to Virchow, of the same histological character as the indurated chancre and the various gummatous formations—namely, an infiltration of tissue with nucleated embryonic cells. These papules are characteristic but by no means frequent syphilitic products in the larynx, and are so infrequent in the trachea that their occurrence there is denied by authorities the very highest. They are multiple recurrent lesions, almost invariably associated with mucous patches on other mucous membranes; usually lasting from three to five weeks, and sometimes much longer. They are observed from within a few weeks to a few months after infection; sometimes earlier, occasionally as late as eighteen months. They are far the more frequent in tuberculous subjects who have contracted syphilis.

The opinion is held by some that superficial ulceration is always due to their disintegration, and that they must have existed in many cases in which they have not been observed. Histologically, they are composed of small-celled infiltrations into the corium and into dilated hypertrophied papillæ. Hence they occur in localities where papillæ exist. Consequently they cannot occur below the vocal bands. They are quite red when recent, but soon change to light gray as the epithelium thickens; they then appear as small, wrinkled, opalescent, flattish, ovoidal elevations, varying in size from pin-heads to small peas; depressed in the centre when mature, and when recent circumscribed with a peripheric inflammatory areola. They may subside without trace. When erosion takes place, the surface becomes punctatedly red from exposure of the papillæ. They may undergo destructive ulceration. They may become the starting-points of small pointed vegetations, histologically identical with papillomata. These are probably non-specific in character, though due to irritation excited by specific processes. They do not undergo ulceration, and rarely undergo absorption under specific medication. When forcibly removed, they repullulate quickly. Similar vegetations sometimes project from the edges of ulcerated patches of tissue. Though usually small, sessile, and multiple, they may acquire such bulk as to interfere seriously with respiration.

The erosions which occur on the surface of the papules, or upon simply erythematous mucous membrane, are usually superficial, but may extend through the mucous membrane and beneath it, under bad hygienic conditions. Under slight provocative exposures to cold and wet, fluxionary œdema sometimes takes place in their vicinity, occasionally to such an extent as to be menacing to life. The epiglottis often becomes very much thickened; the vocal bands thickened and dentatedly eroded. There seems to be no tendency for secondary lesions to extend from the larynx to the trachea.

Tertiary lesions come under notice most frequently in the stage of ulceration, usually following the liquefaction of gummatous nodules, gummatous infiltrations, or true gummata, as may be. The epiglottis is the most frequent seat—so frequently that its lingual and lateral ulceration has been erroneously deemed pathognomonic of syphilis; but destructive

lesions may occur in every portion of the larynx. The ulceration is both serpiginous and deep-seated, and, while more commonly unilateral, there seems practically to be little limit to its phagedenic destructive ravages under unfavourable conditions, as it destroys and penetrates all the tissues, soft and cartilaginous. Slight provocation may produce fluxionary œdema in this stage also, which may be of the most serious character. Serious hæmorrhages may occur from penetration of blood-vessels; and apnœa may ensue from incarceration of fragments of necrosed cartilages and soft tissues. Ulcerations may be attended with proliferative vegetations, which may occlude the air-passages. Superficial ulcerations may heal with moderate cicatrization, which eventually becomes hardly noticeable. Deep and extensive ulcerations heal under peculiar whitish, lustrous, stellate, retractile cicatrices, similar to those which follow burns. Instead of cicatrization, adhesions may take place between contiguous raw surfaces, and strictures of various kinds be formed in consequence.

The gummatous lesions preceding these ulcerations are of three kinds: Small gummatous multiple nodules or nodular syphilides; diffuse gummatous infiltration; and gummata proper, usually isolated.

Small gummatous nodules (nodular syphilide, Lewin) vary in size from that of small bird-shot to that of peas, and are usually grouped in well-defined determinate figures in the body of the mucous membrane, and often so contiguous as to appear confluent. Gummata proper present themselves as firm hemispherical nodules or tumours, from the size of peas to that of cherries or almonds, and sometimes much larger, in the connective tissue beneath the mucous membrane; usually uniform in outline, sometimes lobulated; undiscoloured or reddish at the base and yellowish at the summit. Gummatous infiltrations present themselves as more or less longitudinal or more diffuse submucous thickenings corrugating the surface of the mucous membrane. All these products may undergo absorption.

When not absorbed, gummatous nodules undergo purulent liquefaction. At this time they become softer and more yellowish at the summit, the mucous membrane at the base becoming more inflamed and thickened, the whole mass looking not unlike a furuncle. The summit becomes perforated, and gives exit to thickened, yellow pus, with granular admixture of débris at first. The orifice rapidly enlarges by ulceration until it becomes fully as large in circumference as the nodule was, or larger; and readily coalesces with ulcerations from contiguous nodules. The ulceration extends in depth until it occupies the entire volume of the nodules, and then may penetrate all the tissues beneath, even to the perichondrium and cartilage.

The ulceration of the nodulous syphilide, as studied in a series of cases by Lewin, is said to take place more from periphery to centre than the reverse, being shallow at first and then gradually deepening. The ulcer is round, depressed, and sharply bordered. Its bed is covered with a secretion which, from previous fatty degeneration or purulent metamorphosis, is either thickish, or nearly lardaceous, or composed of purulent detritus.

The more longitudinal and the more diffuse gummatous infiltrations

undergo liquefactive ulceration much more slowly; but the subsequent ulceration, when unchecked, extends much more rapidly and becomes more readily serpiginous and phagedenic; so that, coalescing with similar conditions in the vicinity, large surfaces in continuity become involved in its ravages. As it extends in superficies it penetrates slowly in depth until it also involves the deeper structures close to the perichondrium, and sometimes to the cartilage. Ulceration varies in rapidity, extent, and penetration, according to the succulence or resistance of the tissues contiguous. The ulceration from diffuse gummatous infiltration is preceded, according to Lewin, by extensive fatty degeneration of its surface, which gives it an almost grayish-white tinge. This is soon followed by actual defects which, at first shallow, increase in depth, and gradually penetrate to the perichondrium and the cartilage. These ulcers are characterized, like those from the nodules, by sharp definite circumscription, and by their being surrounded with an inflammatory swollen zone. They appear often as though a piece of swollen tissue had been cut out. The edges are often beset with slight crenations, which give them a gnawed appearance, but are never undermined; and their bottom is covered with a yellowish white adherent mass, composed of pus, fatty detritus, and shreds of tissue. Gummata proper sometimes remain unchanged for prolonged periods. When they undergo degenerative metamorphosis there is formed, according to Lewin, only the characteristic viscid fluid, suppuration being exceptional. Ulceration takes place, however, in some instances, and penetrates deeply into the tissues beneath, as in the other two forms. Under unfavourable hygienic conditions of system, or of surroundings, the phagedenic ravages may become uncontrollable. They have been known to attack an artificial opening made to prevent suffocation by a gumma (Holden, *New York Medical Journal*, January 29th, 1887).

Perichondritis and chondritis being set up after either form, the ulceration may penetrate the cartilage to the tissues external, forming a perichondrial abscess, which ruptures externally by a more or less circuitous route, whence the fragments of dead tissues are discharged.

Taken in point of frequency, the cartilaginous structures seem to be vulnerable in the order following:—Epiglottis, posterior vocal processes, arytænoids, supra-arytænoids, cricoid, cuneiform, and thyroid. Coming to the softer parts, the vocal bands are attacked next in frequency to the epiglottis, the left band far more frequently than the right; the interior supraglottic walls of the larynx, the ary-epiglottic folds, the interarytænoid fold, the posterior wall, the ventricular bands, the subglottic walls of the larynx, the exterior of the soft parts in the pyriform sinus. When the cartilages are attacked, whether primitively or consecutively, the chain of morbid phenomena is perichondritis, chondritis, calcification, caries, necrosis, and elimination of sequestra in crumbled masses and in fragments. The elimination of dead cartilages may consume months, and even years. It usually takes place by the interior route, occasionally by the exterior. In both instances abscess and fistula are formed, and elimination of large fragments by the interior route sometimes produces suffocative paroxysms, and occasionally actual suffocation.

The epiglottis, as repeatedly noted, is especially vulnerable to the syphilitic process, and every variety of lesion possible may ensue in any extent, from insignificant erosion to complete destruction, the character of the lesion depending upon that of the structure destroyed. It is this, as pointed out by Seiler, which gives such an irregular conformation to the epiglottis when its glands have been destroyed. Exulceration of the entire mucous membrane at the edge reveals the exposed cartilaginous structure as a yellowish-white stripe imbedded between two thickened masses of spongy-looking tissue. Ulceration of the cartilage often commences at the anterior surface in the form of a round ulcer with thickened excavated edges. Destructive ulceration usually progresses from the side and from the edge. When the valve is only partially destroyed, its remains may present two or more irregular fragments separated by fissures of varying depth, or a single fragment of any breadth, from a small stripe to nearly the entire bulk.

When totally destroyed, the orifice of the larynx is separated from the post-lingual sulcus by a more or less irregular ridge of ulcerated tissue, which, after cicatrization, presents itself as a pale, deformed stump. This, however, does not, as a rule, prevent deglutition, and in some instances does not even interfere with it, the occlusion of the larynx being effected by the base of the tongue on the one hand, and by close approximation of the ventricular bands and sphincter-like approximation of the ary-epiglottic folds of the other.

The other cartilages, when the subject of destructive progressive ulceration, are macerated out of their investments, as it were. The ulcerative process extends into the cartilage, surrounding it, if it is a small one, or circumscribing a portion of it, if it is a large one. The cartilage then perishes by necrosis, is laid bare, and becomes detached from its connections, in some instances remaining entangled in a sort of pocket scooped out of the soft tissues. The necrosed cartilage finally breaks through to the interior, and is usually discharged by expectoration. If it is situated below the glottis, paroxysms of suffocation may ensue, or even actual apnœa, as from any other foreign body. Exfoliations of the cricoid cartilage are the most frequent source of these untoward results, which, however, sometimes ensue from exfoliations of the thyroid. The ulcerative process sometimes penetrates blood-vessels, and hæmorrhage follows. Such hæmorrhage has been known to terminate fatally (Turck).

The vocal bands frequently sustain permanent lesion, varying from minute losses of substance to entire destruction. Transverse dentated erosion of the border is not uncommon, and detachment from the posterior vocal processes not infrequent. Sometimes abundant irregular papillary proliferations take place, forming mobile, projecting, pyramidal, or irregular dentritic vegetations, which project like soft, mobile stalactites into the interior, and which are large enough, in exceptional instances, to demand operative interference. Similar conditions and productions may prevail with the ventricular bands. Superficial ulcerations may heal with moderate cicatrization, which eventually becomes hardly noticeable. In deep and extensive ulcerations, when cicatrization occurs,

a peculiar lustrous, whitish, stellate, contractile cicatrix is formed, similar to the syphilitic cicatrix in other mucous membranes. Instead of cicatrization, adhesions often take place between ulcerated surfaces, and thus a variety of injurious morbid conditions occur. The vocal bands may become united by a broad fibrinous band stretching between them, or by a similar obturator formed of their thickened and distended mucous membrane. The membranous web thus formed between the vocal bands usually unites them for a variable distance, commencing at the commissure, the posterior border of the structure being crescentic in outline. Exceptionally the cords may become involved throughout their entire length, with an orifice in the central portion of the web (Navratil). This membranous union has been known to take place in six days (Rossbach, Langenbeck's "Archiv," vol. xiv.). In a case watched by Sommerbrodt ("Berlin klin. Woch.," April 1st, 1878) the anterior third united in fourteen days, and the union of the bands was complete in six weeks. In other cases the vocal bands become united without any membrane intervening. Other adhesions sometimes take place, which may seriously impair deglutition, phonation, and even respiration. These comprise depression of the epiglottis to one side or the other, or to an ary-epiglottic fold, and preventing proper closure of the valve or complete elevation; adhesion of the epiglottis to either lateral pharyngeal wall; adhesion of ventricular to vocal band, sometimes preventing closure of the glottis, and often producing a shrill, weak, piping voice; adhesions anteriorly of the two vocal bands or of the two ventricular bands; adhesions of the inner surfaces of the mucous membrane of the arytænoid cartilages, so as to fix the vocal bands immovably in the median position. Other results of syphilitic laryngitis are hyertrophies, diffuse and discrete, of mucous membrane, connective tissue, or muscular substance, and consequent stricture, varying in extent, locality, and interference with function; myopathic paralysis, muscular atrophy; and the development of morbid growths.

Perichondritis or chondritis, whether following ulcerative destruction of the soft tissues or preceding it, usually excites considerable fibrinous infiltration into the adjacent submucous connective tissue, producing a chronic fibrinous œdema. When extensive, this produces suffocative symptoms, and may threaten asphyxia. Sometimes the submucous infiltrations become organised and transformed into dense fibrous tissue incapable of undergoing absorption, and thus they produce deformity, occlusion of the larynx, and stricture. The strictures are often incapable of yielding to systematic dilatation, even when instituted early; and hence tracheotomy is usually necessary to provide artificial means for respiration below the seat of obstruction. After tracheotomy, the process may progress to complete obliteration. These strictures are of the most varying form and calibre, some of them distorting the configuration of the interior of the larynx almost beyond recognition. Fortunately, most of them occur in the supraglottic region, where they are far more accessible to effective treatment.

Lesions of either soft tissues or cartilage in the neighbourhood of the important crico-arytænoid articulation excite non-specific inflammation

of the joint, which may produce true or false ankylosis. Syphilis is probably the most frequent cause of this lesion. When the specific process invades the joint the ligaments and perichondrium suffer, and true ankylosis, or luxation, or disarticulation, and even discharge of the arytænoid and supra-arytænoid cartilages, may ensue. In the latter stage of unrestrained lesion the cachexia is much the same as in analogous advanced stages of tuberculosis.

Myopathic paralyses of the muscles of the larynx may occur in the later periods of secondary syphilis, and at any period of tertiary syphilis. They are most frequently unilateral, the left side being affected far oftener than the right. The onset is often sudden or acute, following severe or sudden exposure to cold and dampness. The paralysis often affects the dilator muscles, and bilateral paralysis of the dilators is not infrequent. Paralyses of the arytænoid muscle and of the entire constrictor group are the most frequent varieties. These paralyses differ in their pathological origin from other examples of paralysis in syphilis, which are due, respectively, to compression of the tract of the nerve-supply by diseased tracheo-bronchial glands or other structures, and to neural or cerebral lesions which present themselves in the latter stages of the confirmed dyscrasia.

Tertiary lesions of the trachea are first observed so very frequently in the stage of ulceration that it has been assumed that tertiary syphilis of the trachea always produces ulceration (Vierling). Schech and others have reported instances of resorption of gummata under specific medication. The clinical tendency, however, is to ulceration. Tracheal ulcerative lesions are sometimes unassociated with lesions elsewhere in the aerial tract. Much more commonly they are found associated with similar lesions in the larynx, in the bronchi, or in both.

Pharyngeal syphilis exists in many instances (thirty out of forty-six collated by Vierling), and pulmonary syphilis in not a few (six out of fifty, Schech). They are often found associated with additional syphilitic lesions at a distance. In a large proportion of instances a primitive bronchus is affected, the left one the more frequently; in some, both primitive bronchi; in a few, the smaller ramifications (Vierling); and, exceptionally, even the minutest (Lancereaux). In some instances syphilitic lesion is confined to the bronchi (five cases by Vierling). The upper portion of the trachea suffers most when the larynx is involved; the lower portion, when the disease is isolated or associated with syphilis of the bronchi. In some instances the middle portion alone suffers (Vigla and Charnal, Berger, Mackenzie of Baltimore, Semon); exceptionally, the two extremities, with complete conservation of the middle portion (Tessier, cited by Rey).

When not occurring in direct continuity with similar lesion in the larynx, the most frequent seat of ulceration is in the anterior surface of the lower portion of the trachea just above the bifurcation, whence it extends upward, or in patches continuously sometimes as far as the cricoid cartilage; sometimes almost completely around the interior in periphery, occasionally completely around. Multiple perichondritis is easily set up and results in abscess, denudation of cartilage, calcification,

caries, and necrosis. Portions of dead cartilage are sometimes coughed up in fragments. Sometimes semi-detached portions project into the interior, and interfere seriously with respiration and with expectoration. The ulceration usually begins in a number of small ulcers, which extend in depth and in periphery, baring the perichondrium, and causing portions of the cartilaginous rings, or entire rings, to undergo denudation, necrosis, and exfoliation. Coalescence with similar ulcerating surfaces or phagedenic extension sometimes produces very extensive ravages, which may involve nearly the entire circumference of the trachea, and nearly, occasionally quite, its entire length. Flaps of detached membrane sometimes fall over, producing valvular impediments to inspiration, or to expiration, according to the position of the attachments. The cicatrization of annular ulcerations produces stricture often so low down as to be beyond relief even from tracheotomy, the parts not being well adapted to respond to artificial dilatation. The strictures are irregularly ovoidal in shape, sometimes funnel-shaped, and of varying thickness, from a few lines to that of several rings. These cicatrices may reduce the calibre of the trachea so considerably as to prevent respiration. Occlusion to the calibre of a crow-quill is not uncommon, and still greater occlusion has been noted in some instances. Annular stricture at the bifurcation may become so great as barely to admit the passage of a delicate probe (Obtulowicz, "Ctrlbl. f. Chir.," 1879, No. 7). Irregular annular dilatation of the trachea is often produced by the pressure of the air-current above the stricture and sometimes below it. Even dilatation of the bronchi has been noticed. Projecting ridges of cicatricial tissue below the point of stricture are sometimes so located as to occlude the inferior orifice of a tracheal cannula more or less, a point not sufficiently recognized, for it might be practicable in some instances to push a cannula into a position which would allow its inferior extremity to pass the obstruction.

Stricture of the bronchi is rare. It affects the left bronchus more frequently (Verneuil *et al.*); sometimes the right one (Wilks *et al.*); occasionally both (Virchow *et al.*). The connective tissue around the strictured portions usually undergoes permanent sclerotic proliferation. Sometimes there is great peritracheal sclerosis, sometimes none. The peritracheal glands may undergo great enlargement. All these conditions, super-added to the internal stricture, may greatly increase stenosis.

Ulceration sometimes penetrates through the trachea, producing abscess opening into the œsophagus or the mediastinum, the aorta (Rokitansky, "Path. An.," Bd. 111, p, 22; Wilks, "Trans. of the Path. Soc. of London," 1865, p. 52), the pulmonary artery (Kelly, *id.*, 1872, p. 45), or the vena cava (Turner, *id.*, xxxvii, p. 117). In at least two instances of ulceration of the left bronchus the left branch of the pulmonary artery has been found perforated (Vierling).

Inflammation around the trachea or bronchi sometimes produces adhesions to the œsophagus or to other tissues, which depresses the trachea and larynx, and impairs their upward movements in deglutition. Sometimes it produces peritracheal or tracheo-bronchial abscess.

Abscess of a bronchus, sometimes deeply seated, has occurred after tracheotomy, apparently as a result of too assiduous swabbing of the cannula.

The lesions of hereditary spyhilis are almost identical with those of the gummatous infiltrations of tertiary syphilis. They sometimes appear very early. Ulcerations have been noticed in infants at two months of age (Parrot, "Prog. méd.," 1878, p. 653). Stricture from perichondritis has been noticed at the same age (Fränkel, "Wien. med. Woch.," 1868, No. 18; Parrot, *loc cit.*).

(*To be concluded.*)

ON ATROPHIC CORYZA (ESSENTIAL OZÆNA).

By Dr. E. J. Moure (Bordeaux).

Under the name "Essential Ozæna" we comprise an affection of the nasal fossæ, non-ulcerative, and characterized by enlargement of its cavities, and accumulation of secretions possessing a fœtid and characteristic odour well-known to everyone. We eliminate the great proportion of nasal affections in which a bad odour is a more or less transient symptom, but often secondary to the alteration of the mucous membrane or the nasal skeleton. If we consider the different theories advanced to explain the origin of this odour, we may remember that Zaufal was the first to affirm that ozæna was the consequence of excessive largeness of the nasal fossæ, originating itself from an exaggerated and congenital smallness of the inferior turbinated bone, and, to a less degree, of the middle bone. At the onset of puberty this disproportion being more accentuated would cause the symptom ozæna to appear. The force of the expired current of air is then found to be notably diminished, and there results an insufficient cleansing during expiration and accumulation of mucus in the cavities of the nose. Then decomposition occurs, in consequence of their arrest in a warm and constantly moist spot. This theory, very seductive apparently, has found partisans abroad (Hartmann, Morell Mackenzie, Semon), as well as in France, and Doctors Calmettes and Martin are especially ardent supporters of this view. But as well as these there are opponents; and shortly after Zaufal enunciated his theory, Fraenkel of Berlin established the fact that ozæna was the consequence of a special inflammation of the pituitary mucosa, and that this, hypertrophied at first, became atrophied later on. Thus was explained both the abundant secretion and its decomposition in the enlargement of the nasal fossæ. We have to do shortly with a special chronic coryza, which tended to cause atrophy of the pituitary mucosa, whence the enlargement of the nasal cavity, and decomposition of secretions favoured by different conditions, which Zaufal evoked. Gottstein and Bayer supported this theory, which, however, did not satisfy Michel of Cologne. This last observer, finding that none of the preceding theories explained the abundance, often considerable, of the secretions in this disease, emitted the opinion that the greater part of the exudations which

accumulated in the nose, came really from accessory cavities, and especially from the ethmoidal and sphenoidal sinuses. Lastly, I will quote only from memory the opinion held by Rouge that the affection had an osseous origin.

Side by side with these theories, which explain, more or less satisfactorily, the production of secretions and their arrest in the nasal fossæ, it was necessary to regard the composition of the excretory products, and to endeavour to find an intimate cause for this putrefaction—that is, an origin of the ozænic odour. It was thus that Ziem came to emit the hypothesis of the existence of a special ferment, which, however, he did not further define. Bresgen and Massei believed in the existence of a micro-organism; the latter, indeed, published a detailed chemical analysis in 1882 made by Dr. Arena upon products obtained from patients affected with atrophic coryza. Krause believed in the existence of fatty acids favouring the decomposition of mucus; but, as our distinguished colleague, Dr. Ruault, rightly observed at the last meeting of the French Society of Otology (April, 1887), it was Lowenberg who first made the greatest step in advance. He, in effect, discovered a micrococcus of large dimensions (1 μ to 1 μ 65) in ozænic secretions, which could be cultivated in gelatine, and gave to these cultures the characteristic odour of ozæna.

Such is then, in a few words, the state of this important question, to which recent researches and observation have added nothing new. If it were necessary for me to emit an opinion upon the pathogeny of atrophic coryza, based upon clinical examinations and on careful observations, I should say at once that Zaufal's theory—that is, the theory of congenital atrophy of the inferior or middle turbinated body, appears to me absolutely insufficient to explain the exudation of the production and its decomposition. Do we not meet every day with patients of a certain age, whose nasal cavities are extremely enlarged, and in whom all the conditions favourable for the development of ozæna seem to exist, but yet who are found upon examination to have secretions little thickened, dried, and having no bad odour? Is the enlargement consecutive to the ablation of tumours (polypi, fibromas, sarcomas, etc.) followed by lasting ozæna? If some practitioners are disposed to answer yes, I must tell them that they have not followed their patients for a sufficiently long time. I am quite aware that after an operation which has enlarged the nasal cavity, the secretion, thickened and even purulent, accumulates in the nasal fossæ, that it even decomposes and produces tolerably marked ozæna. But this is only a temporary phenomenon, which will disappear after a period more or less long, according to the nature and extent of the traumatism. With regard to this point, to cite only one example amongst many, I recall the case of a patient suffering from fibro-sarcoma of the right nasal cavity, the details of which have already been made public ("Bull. de la Soc. Fran. d'Otol.," 1886, Tome 3, Fasc. 2, page 140). This patient, who was operated upon for the tumour, and cured without recurrence, had for the first year afterwards all the symptoms of an atrophic coryza, and in her case the inferior and middle turbinated bodies displaced by the tumour were absolutely rudimentary. After a year's treatment the symptoms

amended, and now for more than a year she has been without nasal treatment. She, however, recommences the latter at the end of an acute coryza with which she is sometimes afflicted, ensuring thus that the affection will not pass beyond its usual limits. It is scarcely necessary to add that the nasal fossa is always very large, and that it permits examination of the superior pharyngeal wall by anterior rhinoscopy, only the secretion is modified in nature and quantity. If, then, simple enlargement of the nasal cavities, whether congenital or acquired, does not suffice to explain the often late appearance of the disease (at fifteen or twenty years of age), it is evident that a more complex factor must be admitted to be the case. So, with Fraenkel, Gottstein, Bayer, and many others, I would more willingly admit the existence of a glandular inflammation of the mucous membrane which clothes the nasal cavities, or even the accessory cavities, as Michel imagines. The secretion must contain—this goes without saying—some micro-organisms, whether diplococcus or other, which would produce decomposition in the secreted liquid, this being especially favoured by the sojourn of mucus in the nasal cavities too large to admit of perfect cleansing. This is, in short, an eclectic theory, in which I give and take from each author the part which seems admissible ; the glandular theory has, moreover, in its support the interesting microscopical researches of Habermann ; and if Zuckerkandl has been able to state in opposition to Michel's theory that the ethmoid was very little developed in subjects with rudimentary inferior turbinateds, I can affirm that there are cases in which the mucous membrane which clothes the sinuses, is inflamed, and allows the flow of a purulent and pretty fœtid secretion. It is in cases which are rare, it is true, that atrophy of the inferior turbinateds was so considerable as to allow a view of the orifice of the sphenoidal sinus, that I have been able to observe this fact.

It is, then, quite allowable to conclude that the secreted product may, at least in some cases, come from the accessory cavities. The glandular theory has again in its support the observation of a patient, in whom one often sees on the surface of the mucous membrane, which is more or less granular and rugose, drops of yellow pus, or rather of a dirty grey, having some analogy to small hemispherical perles, which are not long in becoming confluent and flowing into the nasal cavity just as sweat drops on the cutaneous surface, with this difference that the drops are of a much less volume. This secretion in some patients, scarcely even exhaled, possesses a fœtid odour, just as the perspiration of some subjects is insipid, sour, and even absolutely fetid and repulsive (the Negro race, Mulattoes, blondes, etc.), and hyperidrosis of the feet. The glandular theory explains the notable hyper-secretion of the mucosa and its hypertrophy, which is sometimes met with at the commencement of the affection. It also explains the almost spontaneous disappearance of ozæna, when the patient is aged, and atrophy has arrived at its extreme degree. At this period the almost total disappearance of the glandular tissue hinders the production of the secretion and its decomposition, although the nasal cavities may have obtained their maximum of enlargement. This fact, already noticed by Trousseau, is especially observed

in old people, amongst whom the so-called essential ozæna is rare, as everyone knows. How is atrophy of the mucosa produced, and especially of the osseous tissue of the inferior or middle turbinated bodies? This is evidently a problem difficult to solve. Is it, as our distinguished *confrère*, M. Gellé says ("Rev. de Laryng." 1887, No. 6), from insufficience or arrest of nutrition of the osseous tissue, consecutive to the evolution of lesions of the mucous membrane, or to a veritable sclerotic interstitial rhinitis, in which the connective tissue proliferation occludes the vessels and hinders nutrition, as is observed in the liver, kidney and other organs? It is evidently to pathological anatomy that we must turn in order to find the solution of this part of the problem. It is well recognised that one finds hypertrophy of the inferior turbinated bodies in many patients—that is, of their anterior or posterior parts—which is followed by notable atrophy, of which enlargement of the nasal cavity is the direct consequence.

As to the etiology of ozæna, it may be divided into (1) predisposing causes, (2) exciting causes.

(1) Amongst the first it is necessary to place diathetic influences, and amongst the diatheses scrofula seems to me to play the most important *rôle*, in preparing the earth to favour the development of the disorder. Syphilis has also been equally incriminated, but this last gives rise to a special ozæna, the objective characters of which differ absolutely from those of the affection which now occupies us. Hereditary syphilis, however, may create a predisposition amongst descendants of subjects having this diathesis. Heredity has also been incriminated, and it is necessary to remember that it is not rare to meet with entire families afflicted with this disorder. It is necessary also not to forget repeated inflammation of the Schneiderian membrane, but it is always essential that there should be a ground propitious enough to permit the evolution of the affection, and lymphatism more or less exaggerated, constitutes, as we have already said, a most important etiological factor. As to the influence of age, it is tolerably clear, and all authors are unanimous in recognising, that it is especially during adolescence from ten to eighteen years of age, that is during the age of growth and puberty that the affection is most frequently met with. It is, however, far from being rare in children and even in aduits. It must be remembered also that certain people (Galicians, Poles, Wallachians, Lower Arabians, etc.) are affected with this disorder in an endemic form.

(2) Amongst exciting causes I shall signalise the persistence of causes that occasion acute coryzas, or which keep up chronic inflammations of the pituitary mucous membrane. Exaggerated smallness of the anterior nasal fossæ and immoderate size of the posterior cavity are also causes of ozæna.

I shall not dwell on the functional symptoms, which are pretty well known to all practitioners, I shall merely recall the fact that the external configuration of the nose (the saddle-shaped nose) is, however, a presumptive symptom of the affection. Again, that certain subjects carry on their countenance the marks of scrofula, for these are signs which are far from being constant, and which it is sufficient for me to call attention

in passing. It is the same with regard to change of character and melancholia occurring in certain patients afflicted with ozæna, who pre-occupy themselves beyond reason with their affection and separate themselves from others. Those functional symptoms are important, such as dryness of the throat, a frequent need for deglutition, or necessity of clearing the naso-pharynx, which patients suffer from when the pharyngeal wall is affected (atrophic or dry pharyngitis). One often also observes frontal or supra-orbital headache when the orifices of the sinuses are obstructed by plugs of dry mucus, the odour, generally diminished, is pretty often abolished altogether. As to the secretions, they are much too well known to require particular description. They are masses of greenish puriform crusts forming veritable wads, and having the characteristic odour which has given to this affection the name with which it is designated.

The objective symptoms are, as I have said already, considerable enlargement of one or both fossæ. At the confirmed period of the disorder, the cavities are so spacious that it is very easy to examine the pharynx, the upper portion of the palatine arch, and the orifice of the Eustachian tubes, by anterior rhinoscopy. But this condition is not always so marked, and it is not rare to meet with patients amongst whom, on one side, the turbinated bodies, especially the inferior, are tumefied, red and granular, whilst the other is in a condition of almost complete atrophy. At other times the anterior two-thirds of the turbinated are hypertrophied, the posterior third being already atrophied. It is in these cases that secretions accumulate in the naso-pharyngeal cavity, whence they are expelled with difficulty. We have a pathological condition creating those ozænas called *sine materia*, of which the cause is often not discovered, by reason of insufficient examination. It is therefore anterior or posterior rhinoscopy which will lead to an exact diagnosis of this condition, and will indicate the point which ought to be more especially submitted to treatment. As to prognosis, it will necessarily vary according to the theory of the disorder. It is evident, indeed, that those who admit Zaufal's contention should renounce all hope of cure, since they see in the malady only a simple error of conformation, an arrest of development. Those, on the contrary, who share Fraenkel's opinion, or any of its modifications, will hope to modify the mucous membrane by a more or less appropriate treatment, and to encourage the patient to employ active medication, in order to modify and ultimately arrest the secretion of the mucous membrane. To those who adopt this theory the future of the patient is less grave, and it may be affirmed that a day will come when all local treatment can be abandoned, without fear of return of the characteristic odour of the disease. It should be borne in mind, that in cases well advanced this result will be difficult to obtain; but in the majority of cases, with much patience on the part of the physician and the patient, the happy result will be obtained in the end. How is this cure to be obtained? Is it by regeneration of the atrophied parts; or is it, on the contrary, by the disappearance of almost all the glandular tissue? One must admit, that in advanced and old cases a relative cure takes place in the latter manner; that is to say, the secretion dries up little by

little, and no longer forms those stinking masses of crusts which characterize the disease. Is it possible to obtain the first mode of cure? Being less affirmative than my confrères, Drs. Noquet and Baratoux, I answer somewhat timidly, as I have already done in my Manual, with some reservations on the subject, which I have studied with especial care for many years; and I will further add, that when this work of reparation is produced, it is generally only after pretty long treatment.

I now arrive at the last part of my work, namely, the treatment of atrophic coryza. The first indication is to get rid of the bad odour, and all efforts should be promoted to clearing the nasal fossæ of the mucosities which accumulate there, and which occasion the fœtidity of the expired air. To this end one may apply either the nasal douche (irrigation), the bath, or injection with the syringe or caoutchouc ball. In spite of all the objections, and the so-called drawbacks attributed to it, I much prefer the nasal douche, performed with an irrigator, syphon, or injector. It is scarcely necessary to add that the success of the operation often depends upon the method of employing this proceeding, and that it is most essential to give the fullest instructions to the individual charged with the care of the patient, as to the mechanism, or, rather, as to the way in which he ought to proceed to make the injection. Thus the injected liquid ought always to be tepid, somewhere between twenty-five and thirty degrees. A very feeble jet should be employed, except in certain special indications, and he ought to avoid douching the base of the cranium in directing the liquid towards the frontal sinus. Indeed, if one recalls the fact that, contrarily to the opinion admitted amongst the laity, the nasal fossæ are directed, not upwards to the base of the cranium, but directly backwards towards the pharynx, it will be readily understood how necessary it is to explain to the patient the manner of using the nasal douche.

In my own practice ("Manuel Pratique des Maladies des Fosses Nasales," p. 290), in order to avoid all anatomical explanation, which may be badly understood or interpreted, I do not make use of olives, which are manifestly designed to douche the base of the cranium and the cribriform plate of the ethmoid (see the pictures in all the catalogues of instrument makers), but I use a cannula bent to a right angle. It then suffices to tell the patient to hold the handle of the cannula low towards the chin, from which it is separated about four or five centimetres, and in this manner the jet will be directed backwards towards the pharyngeal wall. During irrigation, the head ought to be slightly inclined forwards and to the side opposite to that in which the cannula is placed, the mouth should be widely opened, and, if necessary, the patient should pronounce the vowel *a*, in order to obtain elevation of the arch of the palate. The patient should be warned that the douche ought almost to make itself, and should provoke no headache, and, if this latter appears after injection, it shows that this has not been made according to the rules which I have indicated.

Irrigation, however, sometimes offers serious objections (posterior cephalalgia, penetration of the liquid into the tympanum), and it will be necessary then to prescribe a nasal bath. This proceeding, recommended

by Löwenberg, consists simply in directing the head of the patient backwards so that the two nostrils form the most elevated point of the naso-pharyngeal cavity. If a medicated solution is then turned into one of the nostrils until it begins to come out at the opposite side, one may be certain that the nasal fossæ are completely filled with liquid. This small operation may be facilitated by directing the patient to breathe through the mouth, or to pronounce the vowel *a*, so as to keep the arch of the palate raised. In other cases, one will employ simple aspirations; but it is necessary to say that they rarely suffice, and we prefer retro-nasal gargling, recommended by Dr. Guinier; but I must repeat, nasal irrigation is much more effective and preferable to other means, and the cases in which one is obliged to reject this mode of treatment may be considered to be absolutely exceptional.

As to Gottstein's method of introducing tampons into the nasal fossæ with the aim of diminishing the cavities and preventing desiccation and putrefaction of the secretions, they are little practicable, and it is difficult to make them easily acceptable to patients, at least in our country. Almost all authors are unanimous in recommending the employment of antiseptics, which are, indeed, the best means for obtaining the disappearance of the odour of atrophic rhinitis, and also for preventing putrefaction and the formation of secretion. The manner in which I habitually proceed, and which I ought to recommend highly in this affection, is as follows:—I prescribe to the patient at once a first irrigation, made with one or two litres of tepid sulphurous water, to which is added either chlorate of potash, bicarbonate of soda, borax, marine salt, a teaspoonful to half a litre of tepid water, or, better still, the mother water of Salis-de-Béarn. When this first injection has had a detergent action at least on part of the nasal fossæ, I follow it with a second one, made with half a litre of tepid water with addition of a tablespoonful of antiseptic fluid, as follows:—

Phenic acid	20	grammes
Pure glycerine	100	„
Alcohol at 90°	50	„
Water	350	„

A tablespoonful to half a litre of tepid water.

The phenic acid is, according to the case, replaced by chloral, resorcin, salicylic acid, salicylate of soda, etc., and often even these medicaments are combined. Other authors recommend solutions of corrosive sublimate, which have the inconvenience of being toxic in small doses, and may sometimes determine disagreeable accidents. I ought to say that at the beginning and every time that the odour tends to reappear, I return to the phenic solution. As a rule, I change the liquid every month, so as to avoid accustoming the patient to the remedies employed. After the nasal douches, the patient ends his treatment either by a pulverization or by an insufflation of impalpable powder, or with nasal humage. I prefer the first or the last of these, which have the advantage of obtaining much better diffusion, and of reaching more easily all the anfractuous parts of the nasal cavity, and of being the methods more easily used by the patient. As to spraying, I am well pleased with the

employment of slightly astringent solutions, such as tannin and alum, made antiseptic by the addition of antiseptic vinegar, resorcin, phenic acid, or chloral. The following formula is worth recommendation in these cases :—

Phenic Acid	2	grammes
Resorcin (Crystal)	3	„
Pure Glycerine	50	„
Water	300	„

For spraying used pure, or with the addition of a few drops of antiseptic vinegar. Another formula is :—

Camphor	8	grammes
Tincture of Iodine	10	„
Tar	12	„
Alcohol at 90°	100	„
Water	250	„

To be warmed and employed for nasal humage for one or two minutes after the irrigation.

Latterly I have used thymol, vaunted by American physicians; but its employment is rather painful even in small doses, and the results obtained are not of such a nature as to induce me to recommend this medicament in preference to others. If sprays are chosen, it is necessary to make them of very short duration, and to endeavour simply to direct the jet into each nostril in all directions. It will often be necessary to make sprays directly into the naso-pharyngeal cavity by means of a retro-nasal spray. I generally advise them to be made scrupulously morning and evening, and in some very rebellious cases three times a day, not only during some months, but entire years, according to the intensity of the disease. If we have to do with a child, and especially with a young girl, it will be necessary in the latter to continue the treatment up to the moment of the appearance of the catamenia, and at least during one or two years after this. It is not rare to see at this time a marked recrudescence in the secretion of the mucosa, and consequently an augmentation of the fœtid odour which reveals the nature of the disease.

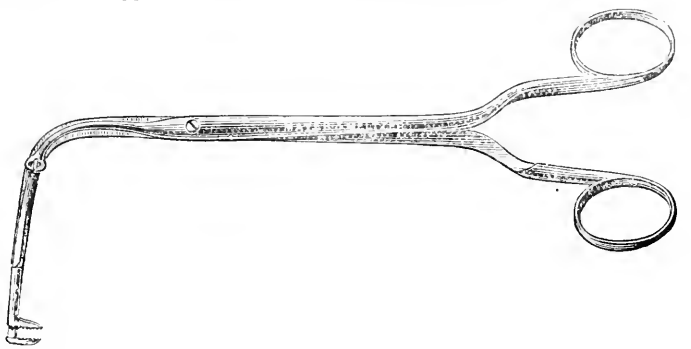
It is perfectly well established that in young girls menstruating the menstrual period (before or after) is that at which the odour is the most tenacious and most pronounced. As to active local treatment to be made by the physician, it may consist either in applications to the mucosa of solutions of nitrate of silver, or even of the galvano-cautery, according to the case and the degree of the disorder. The galvano-cautery can, however, be but little indicated during the atrophic period. It is necessary to add that general tonic treatment—olive oil and its iodised preparations—will find natural indication here.

I do not speak of electrolytic (galvano-caustic) treatment, recently recommended by some authors (Bryson-Delavan, Garrigou-Désarènes, etc.), not having had any personal experience of it. As to surgical treatment (scarifications, ablation of the turbinateds), these are useless mutilations, which do not appear to me to be justified in practice.

NEW INSTRUMENTS AND THERAPEUTICS.

MAYER & MELTZER.—New Laryngeal Forceps.

THESE forceps were designed at the suggestion of Dr. Norris Wolfenden for operating upon a difficult case of hard fibrous tumour, situated in the infra-glottic region under the anterior commissure. The glottic opening being in this case particularly small, the tumour offering but little to grip, it was found impossible to do more than remove a very small fragment with the Mackenzie forceps, which continually slipped off the surface without bringing anything away. Neither the wire loop nor the tube forceps were any more serviceable, but with the forceps here described it was found easy, not only to obtain a good grip, but to remove all but the last traces of the tumour at one sitting. These forceps are very simple in construction, and consist essentially of two arms opening scissors-wise, both of which are somewhat bent at the manual end, which permits the hand to be kept out of the line of sight. The upper arm of the forceps (which becomes the lower blade) is formed of two pieces joined simply by a slot and a small nut; the lower end carries the cutting edge, which works through a groove in the other arm. The cutting portions are formed of two pieces, one attached to the upper and the other to the lower arm of the forceps, and the blades cut from below upwards, the upper cutting edge slightly overlapping the lower one.



The upper blade remains fixed, and by opening the forceps, which of course are introduced into the throat closed, the lower cutting edge can be got well under the growth to be removed. The great advantage of the instrument is its extreme simplicity, its lightness, and its great power, in which points it is fully equal to the Mackenzie forceps, and the smallness of its cutting portion permits it to be introduced through the smallest glottis. The instrument can be made to work in an anterior or posterior direction, or to cut or crush. An illustration is appended.

R. Norris Wolfenden.

JAHR.—New Inhalation Apparatus. *Deutsch Med. Woch.* Nos. 38 and 39, 1888.

AN apparatus for the inhalation of superheated air charged with medicaments. **Michael.**

GOTTSTEIN (Breslau).—**Reply to Dr. Brockmann.** *Monatss. fur Ohrenheilk*, No. 8, 1888.

As Brockmann has said that the tube forceps of Gottstein is a very fragile instrument, the latter has examined the point, and finds that these forceps suffice to bear a weight of 4½ kilogrammes. **Michael.**

CAW, MATTHEW J. (Woolwich).—**The Athmoscope.** *Lancet, May* 19, 1888.

A DESCRIPTION, with illustrations, of an instrument "for the auscultation of breath sounds as they issue from the larynx into the oral cavity." The inventor hopes it may be of real use in the diagnosis of lung disease. **Hunter Mackenzie.**

REICHERT (Berlin).—**On the Local Application of Camphoric Acid.** *Deutsch Med. Woch.* Nos. 36 and 37, 1888.

THE author has used one per cent. solutions of camphoric acid with good result in the treatment of diphtheritis, pharyngo-laryngitis, angina, rhinitis, and tracheitis. **Michael.**

WATSON, PAUL E. (Bristol).—**Combined Nasal and Oral Respirator.** *Lancet, June* 2, 1888.

THIS apparatus is made by Arnold and Son, West Smithfield.

Hunter Mackenzie.

McCLELLAN, ELY. (Surg. U.S.A.).—**Note on the Treatment of External Inflammations of the Upper Air Passages.** *Journ. of the Am. Med. Assoc., August* 18, 1888.

NOTHING new. **John N. Mackenzie.**

ALBITSKI, J. (Kharkoff).—**Case of Phthisis treated by Professor Kremianski's Aniline Method.** *Lancet, March* 24, 1888.

THE treatment followed was the administration of "meat powder" as nourishment, of acetanilide in 10 grain doses as an antipyretic, and of eucalyptus oil, or oil of anise, with pure aniline oil (aniline) as inhalants. The proportion of aniline was a drachm to an ounce of the oil of eucalyptus, or aniseed. Latterly it was found that the eucalyptus inhalations did not suit the patient; the following was therefore used instead: Ol. menth. pip., 2 dr.; ol. anilini, 1 dr.; aq. dest., 1 oz. (The case was treated, but apparently not cured, by the so-called Aniline Method.)

Hunter Mackenzie.

SHEPHERD, R. J.—Phthisis a Disease of the Night. *Lancet, April* 7, 1888.

"PHTHISIS is a disease of the night. It is so simply because we inhabit

hot rooms by day, and cold rooms by night, and many lungs find it more than they can do to accommodate themselves to the constantly recurring change in the temperature." **Hunter Mackenzie.**

BRADDON, W. LEONARD.—Oil of Peppermint as an Antiseptic and as a Remedy in Phthisis and Diphtheria. *Lancet, March* 17 and 24, 1888.

THE author details some experiments which he claims demonstrate the superiority of oil of peppermint as an antiseptic over carbolic acid, iodine, iodoform, and corrosive sublimates. He consequently concludes that oil of peppermint is one of the strongest and most reliable of antiseptic agents. For minor operations he recommends a preparation of olive oil, containing one drop of peppermint in an ounce, and for dressing purposes a gauze containing 1 part in 1,000. He recommends the inhalation of the pure oil in phthisis, and its application as a pigment in diphtheria. **Hunter Mackenzie.**

ADDINSELL, AUGUSTUS W.—The Toxic Effects of Cocaine produced by Subcutaneous Injection. *Lancet, May* 5, 1888.

THE author expresses his opinion that one-half grain of the salt dissolved (at the time) in ten minims of water, and administered by subcutaneous injection, is sufficient for the production of local anæsthesia, and is not apt to be followed by toxic symptoms. **Hunter Mackenzie.**

DIPHTHERIA.

HAMILTON, JOHN N. (Pompeii).—**The Non-Identity of Diphtheria and Membranous Croup.** *American Lancet, October*, 1888.

DIPHTHERIA has a prodromic period of three or four days. Croup occurs suddenly. Diphtheria is produced by a specific poison, infection or contagion. Croup is not, but is dependent upon atmospheric changes, cold and damp, and is a disease of the poor.

Diphtheria has its seat in the throat and mouth ; croup in the trachea. Diphtheria leaves a raw surface, or ulcer, on removing the membrane ; croup never. In diphtheria exudation takes place into, as well as upon, mucous membranes, causing deep lesions, gangrene and sloughing of soft palate, tonsils and uvula. In croup this never occurs, the epithelium being alone affected.

Diphtheria lasts about two weeks, croup about three or four days. In diphtheria the patches are composed of epithelial and granular and fatty cells in croup, of amorphous or fibrillated substance, in which abundant young cells are involved. Albumen occurs in diphtheria, not in croup. **R. Norris Wolfenden.**

JACOBI, A.—Remarks on the Nature and Treatment of Diphtheria. *Brit. Med. Journal, September 22,* 1888.

No specific microbes of diphtheria have been isolated. It begs the question to suggest that there are several species of them, resulting in the production of different forms of diphtheritic deposits and degeneration. Jacobi's own position has always been that ptomaines, which need not be exclusively the result of the metabolism of bacteria, are the causes of many of them. It is certain that in diphtheria the numerous microbes found in membranes are mostly confined to the surface, while the action of the virus penetrates to a great depth. There is probably no spontaneous origin of diphtheria. Foul air and sewer gas do not create it. The propagation of diphtheria from animals to man and the many other ways in which the contagium can be carried negative any idea of spontaneous generation. Like erysipelas it avoids healthy surfaces, but the slightest wound or abrasion invites it. There is only one normal con dition which admits it, namely, the interstices between the tonsillar epithelium. Otherwise, there must be some superficial removal of epithelium, however slight, and this may occur on any mucous surface. The disease is most virulent the younger the patient. Fatal laryngeal diphtheria is rare after puberty. One attack of diphtheria predisposes to others. The character of the membrane depends, to a great extent, on its locality. Wherever elastic tissue is found there is an obstacle to diphtheritic development, thus uncomplicated tonsillar diphtheria or tracheal and bronchial diphtheria, so-called fibrinous bronchitis, may last for a long time without exhibiting septic symptoms. Pavement epithelium yields a firm foothold to diphtheritic changes. Thus the tonsils are favourable to the reception and development of the virus, but it remains local because the elastic tissue of the organ shields the system, and the lymph vessels are too little numerous to cause absorption of the poison. Wherever muciparous glands exist extensive destruction of tissue by diphtheria is prevented, since the secreted mucus assists in removing the membrane. Thus it is that deposits in the nasal cavities and trachea are readily expelled. On the vocal cords the membrane persists in consequence of the absence of muciparous glands, and the immunity of the system from constitutional symptoms is due to the absence of lymphatic communication. Jacobi concludes that membranous croup, if confined to the larynx and not complicated with diphtheria of any other organ, is simply local laryngeal diphtheria. From its histological structure the larynx is the very place for diphtheria to remain local, and the same is true of the bronchi. The pseudo-membranous sore throat of scarlatina has been declared to be distinct from diphtheria, but all the fancied differences are unreal. With regard to follicular tonsillitis, if the little inflamed follicles remain distinct from each other we call it follicular tonsillitis. If the dots prove confluent and coalesce with the contiguous membrane we shall, or ought to, call this diphtheria. Such cases may run a mild course as far as fever and constitutional symptoms are concerned. It is well known that Jacobi considers most cases of follicular tonsillitis to be diphtheritic. The observations of the author upon this point, which are detailed at great

length, should be read in the original. [Dr. Jacobi lays down concise indications for treatment; we have already given an abstract of Dr. Jacobi's plan of treatment. This paper, which is a very interesting one, should be carefully studied by practitioners. One point upon which they can contribute much valuable observation is that of the relation of follicular tonsillitis to diphtheria.] R. Norris Wolfenden.

EDITORS OF LANCET.—Diphtheria. *Lancet, March* 31, 1888.

A LEADING article, having reference to the recent elaborate inquiry of Professor Oertel, of Munich, into the nature of this disease. "The study is a demonstration that diphtheria is at the outside a strictly local disease, but that in a few hours its poison spreads in the part first affected, and in its vicinity; and in a few days it may enter the blood in such amount as to produce the most marked evidence of systemic poisoning, which, if not causing death from its effect on the heart or other vital organs, may in due course produce peripheral neuritis, and perhaps myelitis." In regard to treatment, "the membrane may be dissolved or detached, but the disease is not cured; for the membrane is only the surface indication of a deep-seated and wide-spread change. Nevertheless, it is well to minimize the risk of the extension of the disease by contagion within the body by the free disinfection of the pharynx. As for other treatment—for we have no antidote for the diphtheritic poison—reliance must be placed upon nutrition being maintained." Hunter Mackenzie.

HOPE, G. B.—Some Clinical Features of Diphtheria, and the Treatment by Peroxide of Hydrogen. *Medical Record, October*, 1888.

RATIONAL treatment will depend upon some local agent, which will destroy the specific germ before full development of the constitutional infection. Most active germicides have poisonous or irritant nature, limiting their utility to surface or open wound application. In peroxide of hydrogen, the author thinks that if not a specific, at least we have a most efficient topical agent in destroying the contagious element, and limiting the spread of its formation, and an agent which is, moreover, without any bad constitutional effect. The author's results confirm those previously published by Bleyer. Hope prefers a fresh standard, Marchant's preparation of fifteen volumes, and instead of swabbing the throat he prefers a steady coarse spray under an air pressure of twenty pounds or more. The force of the spray should be sufficient to cleanse the surface and destroy necrosed elements. With peroxide of hydrogen, the exudation is not liquefied, but the cells are broken up, and freed from the entangling fibrous mass. In most cases, two applications a day are sufficient, if thoroughly performed, to arrest all dangerous extension and accomplish the gradual resolution of the local formation.

R. Norris Wolfenden.

RIDGE, J. J.—Naso-Laryngeal Intubation in Diphtheria. *Brit. Med. Journal, October* 13, 1888.

THIS is a new method, which obviates many of the difficulties attending intubation, especially that of withdrawing the tube. The author has

performed the operation four times, twice on one patient. Unfortunately all the author's patients have died, but he thinks that the operation is promising, and deserves further and extensive use. The method is as follows :—Gum-elastic silk catheters are used, the eye is cut off, and the end furthest from the eye, rounded off and smoothed, is slipped along the nostril, the forefinger of one hand guiding it into the larynx. A smaller long tube of the same material can be passed easily down the lumen of the larger tube, the end having several lateral perforations. This end can be passed right into the larynx, and the larger tube withdrawn until its end is out of the larynx. Through the smaller tube a small quantity of peroxide of hydrogen is to be injected, so as to bring it into contact with the interior of the larynx and the false membrane. The small tube in the larynx will act as a guide to the larger one, which can then be pushed back into its place, after which the smaller tube can be withdrawn. The author also proposes to pass another similar catheter along the nostril and into the œsophagus for feeding purposes, and the accident of passing food into the larynx is to be avoided by plainly marking the tube. The author's proposal is, at present, of purely a theoretical nature, since he has not tried it in its entirety, the cases recorded being merely catheterism of the larynx. The method on paper even seems complicated, and we imagine that with one tube in the larynx, and another in the œsophagus, a child's condition would not be very comfortable, and the mistake might easily be made of passing food into the larynx.

R. Norris Wolfenden.

PARKER, R. W.—Some Moot Points in the Surgical Treatment of Diphtheria. *Brit. Med. Journal, September* 22, 1888.

SURGICAL treatment may be divided into—(1), local measures ; (2), operative measures. Local measures consist of the use of strong caustics, sprays, irrigations, and powders for dusting. Parker has found hydrochloric acid diluted with three or four parts of glycerine a most effectual application. It only attacks the diseased parts, and he swabs out the pharynx and posterior nares very freely with this mixture, once, twice, or oftener, if necessary. Glycerine of carbolic acid may be employed. Two or three applications of these caustics usually suffice in as many days, and they must be made with great gentleness. He also believes in the use of weaker astringents, frequently applied. These may be also used effectually in the form of spray. Irrigation is an admirable method of washing away the products of the local lesion. In cases of severe nasal diphtheria he would even administer chloroform, in order to secure thorough cleansing of the posterior nares and adjoining pharynx. In children plain boiled water or boric acid solutions should be used, in the adult sulphate of copper (2 grains to the ounce), corrosive sublimate (1—1000), quinine (5 grains to the ounce). A pint or more of the fluid is irrigated through the nostril by a tube. After irrigation, or in place of it, iodoform or boric acid may be dusted over the surfaces. Operative measures consist of (1), tubage ; (2), tracheotomy. Though the author's experience with the former has been very limited he cannot think that it will ever replace tracheotomy. With regard to anæsthetics, the author

always administers chloroform before tracheotomy. After the performance of tracheotomy itself, the author has latterly entered the trachea by means of two incisions only, the first including the skin and fascia, the second opening directly into the trachea. After opening into the trachea, before the tube is inserted, all false membrane and inflammatory products should be cleansed with a long soft feather, and a solution of a little soda, potash or borax. If membranes cannot be expelled suction must be performed, never with the mouth, but with the author's instrument, or if nothing else be at hand, with a guarded catheter. As to cannulas, the author prefers his angular tube, and attaches less importance than formerly to a double tube during the acuter stages of diphtheria. In fact the inner tube may be discarded if the case is in the hands of a good nurse. The author condemns strongly the bivalve tube. With regard to the moment for operating, the author thinks that tracheotomy might reasonably be recommended in certain cases on purely prophylactic grounds, although at the moment the larynx be quite free from membrane. The author is also very much in favour of the employment of steam and the croup bed.

R. Norris Wolfenden.

GAY, G. W.—The Comparative Merits of Tracheotomy and Intubation in the Treatment of Croup. *Boston Med. and Surg. Journal, October* 11, 1888.

AFTER giving a large number of statistics of both operations, the author goes on to say that intubation is often difficult to perform upon patients under three or over twelve or fourteen years of age ; and at all ages, if the epiglottis and neighbouring structures be much swollen and infiltrated. No force should be used, since the walls of the larynx have been perforated by this means. It is often more difficult to remove than to introduce the tube. Tracheotomy, like intubation, may be easy or difficult. In young fat children, while the trachea lies deep in the neck, is small, soft, and movable, the veins are large and tortuous, and hæmorrhage to be expected, intubation is the better of the two. In septic prostration both are difficult, and the surgeon should choose the one with which he is most familiar. Tracheotomy can be done with one, intubation requires two, at least, assistants. While a patient about to undergo tracheotomy can be quieted with chloroform, the strength and readiness of the assistants is necessary in intubation. The tube may become occluded, and will have to be removed ; and in such cases of bad membranous croup appliances should be at hand for tracheotomy. Both operations require skilled nursing, and where a physician is not ready at hand tracheotomy is the safer. The time that is taken up after tracheotomy in cleaning the tube is occupied after intubation in feeding the patient. After carefully discussing the merits of the two, the author thinks that while intubation is a most valuable operation, it is not as free from objections and complications, and is not so far superior to the old and time-honoured operation of tracheotomy as some of its advocates would lead us to suppose. The mortality attending each is about the same, and there is an equal chance in both of the extension of the disease to the lungs. Still, the author thinks that intubation may be preferred in young

children, and in all cases living at a distance from skilled aid where the tube must be allowed to take care of itself, that it may be resorted to preliminary to tracheotomy, that it may be done for euthanasia; while tracheotomy is indicated where intubation cannot be done, or where it fails to give relief to the dyspnœa in severe cases situated at a distance, or under circumstances in which only ordinary and not skilled assistance can be obtained in an emergency, and it is to be preferred in those cases of intubation which cannot be fairly nourished, either in the natural way or by enemata, etc. It may also be resorted to when the intubation tube is frequently ejected or requires frequent removal on account of obstruction. Intubation is a real advance in surgery, and though each operation supplements neither supplants the other. **R. Norris Wolfenden.**

MICHAEL, J. E. (Baltimore). — **Eight Cases of Diphtheritic Stenosis of the Larynx, in Six of which Tracheotomy was done.** *Maryland Med. Journal, February* 4, 1888.

CONTENTS indicated by title. **John N. Mackenzie.**

THORNTON, PUGIN (Canterbury).—**The Treatment of Diphtheria.** *Lancet, April* 28, 1888.

THE author recommends mercury as the best germicide. It ought to be given by inunction, so as to save the stomach for nourishment.

(Subsequent correspondents share Mr. Thornton's opinion. Leonard Braddon recommends oil of peppermint as possessing higher antiseptic properties than mercury.—REP.) **Hunter Mackenzie.**

BRUCE, J. D. — **Papoid and Veratrum Viride in Diphtheria.** *Medical Record, October* 13, 1888.

THE author has treated a number of cases in this manner, and concludes that the papoid dissolves the membrane very quickly. The veratrum reduces the pulse rate, and the author thinks it would be difficult to decide which of these drugs he was most pleased with in the treatment of diphtheria. **R. Norris Wolfenden.**

CHOLEWA (Berlin). — **Menthol in Diphtheria of the Nose.** *Therapeut. Monatssch., June,* 1888.

THE author recommends the treatment of nasal diphtheria by introduction of cotton wads charged with menthol into the nasal cavities.

Michael.

MOUTH, TONSILS, PHARYNX, &c.

STEWART, W. R. H. (London).—**A Peculiar Case of Syphilis of the Mouth.** *Lancet, June* 30, 1888.

A MAN, aged fifty-three, first consulted the author in 1883. The whole of the roof of the mouth and parts of the inside of the cheeks were covered with closely-packed papillæ, about the size of the ordinary circumvallate papillæ, the dorsum of the tongue having also some smaller ones scattered over it. He had had a chancre thirty years previously. The disease resisted every form of antisyphilitic treatment. In 1887 the disease not only persisted, but had spread all round the cheeks and over the greater part of the under lip, and over the soft palate and uvula. Iodide of potassium and mercury appeared at first to have no effect on it, but subsequently under their use, combined with cod-liver oil, a mouth wash of lotio nigra, and a pigment of sulphate of copper, complete recovery ensued. It is deemed worthy of special note that the same treatment, when tried three years previously, had signally failed. The patient had had the advantage of tonic treatment between the first and second periods of the latter stage of antisyphilitic medication.

Hunter Mackenzie.

FRANKEL, EUGEN (Hamburg).—**On the So-called Aphthous Stomatitis, especially in its Anatomical and Pathological Aspect.** *Virchow's Archiv.*, Bd. 113.

THREE cases have enabled the author to make exact pathological researches. Microscopic examination confirms the view of Henoch, that there is a fibrinous exudation in the superficial portion of the mucous membrane. Search for micro-organisms showed the presence of staphylococcus pyogenes-flavus, but no other micro-organism. Michael.

MAXWELL, THEODORE (Woolwich). — **Resorcin in Chronic Painful Ulceration of the Tongue.** *Lancet, April* 21, 1888.

THE application of resorcin powder was followed by an almost complete cessation of pain and subsidence of swelling. Hunter Mackenzie.

POTTER, F. H.—Tuberculosis of the Nose, Mouth, and Pharynx. *Buffalo Med. and Surg. Journal, February*, 1888.

TUBERCULOSIS of the nose occurs in two forms, as an ulceration or as a neoplasm. The ulceration is usually situated upon the septum, the neoplasms are always found on the septum. Their character must be determined by the microscope. After removal there is an inclination to recurrence and to ulceration, which may cause perforation. Some writers, *e.g.*, Bresgen, consider these tumours to be lupoid and not tubercular. The tubercular process occurs oftener in the pharynx and mouth

than in the nose. In point of frequency they occur in the following situations: tongue, pharynx, gums, velum palati, tonsils and cheeks, occasionally also upon the lips. Of seven cases of buccal tuberculosis reported by Delavan three were primary, and of twenty-four cases of lingual tubercle nine were primary. The local manifestations of tubercle in the mouth and pharynx are ulcers, granules, and small tumours. These primary lesions are often capable of successful treatment. There is some evidence to show that these conditions are contagious. The author speaks highly of iodol. Lactic acid has proved disappointing; he thinks well of menthol, using it in solution in oleum petrolina of from 5 to 30 per cent. Surgical measures consist in scraping the ulcer, or excising or destroying it with the cautery. Large neoplasms can be removed with the snare and the base cauterised.

R. Norris Wolfenden.

SCATLIFF, J. M. E.—Night Terror and Screaming of a Child cured by Removal of the Tonsils. *Lancet, October* 6, 1888.

A SHORT relation of a case of this kind, examples of which occur so commonly in throat practice.

R. Norris Wolfenden.

CAGRIN, E. B.—Gangrenous Tonsillitis; Fatal Hæmorrhage. *New York Medical Journal, September* 1, 1888.

THIS was a case of a coloured male, aged forty-five, who, seven days after the onset of pharyngeal inflammation, was attacked with fatal hæmorrhage from the mouth and nose. At the autopsy extensive ulceration was found occupying the site of the right tonsil, and extending for some distance on the post-pharyngeal wall. On this a large slough was attached. On this ulcerated surface, formerly occupied by the right tonsil, were visible the open mouths of two small vessels, which were evidently the source of the hæmorrhage. [It is a pity that the anatomical source of the hæmorrhage was not more accurately determined.]

R. Norris Wolfenden.

ALLEN, HARRISON (Philadelphia).—**On Gouty Sore Throat.** *Med. News, June* 16, 1888.

ALLEN first gives a *résumé* of the literature of the question, and then describes the disease as he has met with it, supplementing his article with five illustrative cases. Subjects of gouty sore throat are almost all middle-aged. Sometimes a family predisposition is present; the distress may be found in the throat, or be referred to it from a catarrh of the nasal passages. It is not apt to develope during an acute attack, but occurs in those prone to neuralgic forms of irregular gout—especially of the viscera—or in persons of gouty habit who are careless in diet. The only ailment with which it may be confounded is the irritable throat of lithæmia. The latter occurs at any time of life, is often dependent on diet, and can be controlled by withdrawal of wines and nitrogenous food, and by increasing the action of the kidneys. Perhaps the best guides to the gouty condition are the permanent teeth. While not essential to diagnosis, the teeth are large, the antero-posterior diameters being

especially exaggerated, the enamel thick, and yellow in colour. These peculiarities are confined to the incisors, canines, and bicuspids. The crowns are often marked by transverse lines, and the bases of the lingual and palatal surfaces are apt to be gibbous. The cutting edges of the crowns of the incisors are without serrations. A disposition exists for recession of the gums from the necks of the teeth.

In the local treatment all agents must be soothing in character. Operations are not well borne. If demanded, they must follow the use of general remedies.

John N. Mackenzie.

HEWISH, E. M. (Philadelphia).—**Acute Infectious Pharyngitis.** *Medical News, September* 8, 1888.

THIS was described by Senator as "primary" and "perhaps always fatal." Five cases had occurred to this observer, and in all the disease ran an acute course, ending in death in a few days, and affecting persons previously healthy. It began with cervical pains and dysphagia, with fever, followed by hoarseness and loss of voice, and finally, the sensorium was affected. The condition anatomically consisted of diffuse purulent infiltration of the deep tissues of the pharyngeal mucous membrane, extending to the trachea and glands of the neck, and involving also other parts, *e.g.*, the stomach. Senator was of opinion that many cases of this kind had been mistaken for acute œdema of the larynx; and it was thought that Morell Mackenzie's "typical œdematous laryngitis" of septic origin was probably this disease. In Senator's cases the spleen was generally enlarged, and the kidneys showed parenchymatous inflammation, and one case was accompanied with a peculiar exanthem. No specific micrococcus was found in the blood either before or after death, and cultivations were harmless when injected into rabbits. Virchow and Guttmann argued that the cases were probably erysipelatous. Hewish has met with a case in a gentleman, aged forty-two, who first complained of trouble in swallowing, and whose fauces, tonsils, and uvula, were congested. There was lassitude, pains in limbs, hoarse voice, and much mucus. The temperature was 101 deg. F., and pulse 90. In three days the patient took to bed, and increasing articular stiffness failed to obtain relief from salicylates. Symmetrical cervical tumefaction occurred; dysphagia increased, the tonsils became much enlarged and hard, with no tendency to abscess formation; voice became husky, and there was dyspnœa. These symptoms increased in severity, especially the dyspnœa, until tracheotomy was performed, but gave no relief, and the patient died on the ninth day. No autopsy was permitted.

R. Norris Wolfenden.

PELTESOHN (Berlin).—**Three Cases of Empyema of the Frontal Sinus and Orbit.** *Centralblatt für Augenheilk.*, 1888.

IN all cases there was a protrusion of the bulb. The cases were cured by incision.

Michael.

BEHAGG, A. J.—The Treatment of Pharyngeal Catarrh. *Brit. Med. Journal, September* 29, 1888.

ONE method employed by the author is syringing through each nostril

with a solution of from 15 to 20 per cent of menthol in olive oil, so as to bring it into contact with the back of the throat. Half a drachm may be injected through each nostril. It has an anti-catarrhal and anæsthetic effect, arresting purulent or muco-purulent secretion. The application may also be made by a brush. It relieves headache and dryness of the upper parts of the pharynx, and has cut short acute suppurative inflammation of the tympanum. When catarrh has spread to the Eustachian tube the author has found benefit from Valsalvian inflation of the ears by steam medicated with equal parts of tincture of iodine and acetic ether (30 minims to a pint of water). After the acute stage is over the Politzer bag or Eustachian catheter should be employed. 25 per cent. solution of menthol in olive oil applied to the pharynx in acute inflammation relieves pain and dysphagia and shortens the duration of the attack; 15 to 30 minims of a 15 per cent. solution may advantageously be employed to the larynx. For acute tonsillitis the author speaks of chlorate of potash, quinine internally, guaiacum, internal and external application of ice, inhalations and poultices, and painting the pharynx with strong solution of menthol. The author deals in great detail with the treatment of acute and chronic conditions of the naso-pharynx and pharynx. His paper does not bear abstraction, and contains little that is new to a specialist.

R. Norris Wolfenden.

KNIL (Moscow).—**A Case of Œsophagotomy for Carcinoma.** *Petersburg Med. Woch.*, No. 37, 1888.

THE cancer was located in the upper part of the œsophagus, for which the author performed œsophagotomy. A Nelaton tube was introduced into the wound, and the patient fed through this. Stenosis of the larynx eventually occurred some months later, and for this tracheotomy was performed. Death occurred sixteen months after the first operation, from hæmorrhage from the tracheal wound. **Michael.**

PAINTER, E. T.—Œsophageal Stricture. *Amer. Practitioner, September* 29, 1888.

SLIGHT difficulty of swallowing had occurred six years before in the patient—a woman of thirty-eight—which increased "until neither water at ordinary temperature, nor cold drink of any sort, nor solid food had entered the stomach for a period of years." A band of constriction could be felt with an œsophageal bougie, which would, however, give way and allow the bougie to easily slip through it after a time. Applications were made of a constant current, placing the positive pole within the constriction three times a week. After the fifteenth application meat and bread could be swallowed. After twenty-five applications, lasting three months, the patient could eat without regurgitation, so long as the meat was cut up finely. The contracting ring persisted, but it had lost all irritability. Carcinoma, or aneurism, was excluded from the diagnosis. The exact level of the stricture was sixteen inches from the incisors. **R. Norris Wolfenden.**

NOSE AND NASO-PHARYNX.

POTTER, F. H.—A Case of Congenital Bony Occlusion of the Anterior Nares. *Buffalo Med. and Surg. Journ., September*, 1888.

ONLY two cases of this abnormality have previously been recorded. The author's case occurred in a child aged two and a quarter years, who had nasal stenosis and noisy breathing since three weeks old. A cup-shaped depression was found in the left nostril, about three-eighths of an inch within the orifice. A trochar was first introduced and pushed through the bony tissue, and then a small galvano-cautery knife, and the opening enlarged to the size of the right nostril. Tampons, saturated with four per cent. menthol in oleum petrolina were then kept *in situ*. The operation was successful, and the author believes that such cases should be operated upon early, when the growths are not so dense and firm as they would ultimately become. R. Norris Wolfenden.

ZIEM (Dantzig).—**On Narrowing of the Visual Area by Disease of the Nose and Accessory Cavities.** *Berlin Klin. Woch.*, No. 37, 1888.

A LADY, thirty-seven years old, had lost one eye through glaucoma. Some time afterwards the vision of the second eye became impaired. Trephining the antrum of Highmore removed a quantity of fœtid pus from this cavity, and cured the condition. The author believes that similar diseases of these cavities lead to grave affections of the eyes. Michael.

HINGSTON-FOX, R.—Nasal Catarrh and Aprosexia. *Lancet, May* 12, 1888.

THE term "aprosexia" has been applied by Dr. Guye, of Amsterdam (one of our collaborateurs), "to the symptom of inability to fix the attention on any subject—a kind of mental lassitude." This may be associated with acute and chronic nasal affections, owing to the fact that the lymphatics entering from the anterior region of the brain into the nasal fossæ become more or less occluded, with the result that exhaustion of the cerebral centres from retention occurs. Treatment must of course be directed to the abnormal nasal conditions. unter Mackenzie.

PEEBLES, THOMAS C. (Lutterville, Md.). **Cases of Foreign Bodies in the Ear, Nose, etc.** *Maryland Med. Journal, August* 18, 1888.

BEANS, grains of corn, pins, etc. Reports five cases. Nothing worthy of remark. John N. Mackenzie.

DOWNIE, J. WALKER (Glasgow).—**Remarks on Some Aural Reflexes.** *Lancet, June* 9, 1888.

AMONGST other reflexes, laryngeal troubles, indicated chiefly by "ear-cough," are described and illustrated by reference to various cases. The

author also describes the mechanism of epileptiform seizures, when associated with aural polypus as the peripheral irritant.

Hunter Mackenzie.

FENGER, CHRISTIAN (Chicago).—**Living and Dead Osteomas of the Nasal and Accessory Cavities. Illustrated by a case of Encysted Orbital Osteoma originating in the Ethmoid Bone.** *Journ. of American Med. Assoc., August* 11, 1888.

AN excellent article on the subject, which should be read in the original.

John N. Mackenzie.

BUCK, A. H. (New York).—**Reflex Influence in the Production of Naso-Pharyngeal Catarrh.** Paper read before American Otological Society, *July* 17, 1888. Rep. in *Med. News, July* 28, 1888.

THE author discusses the questions of reflex catarrhal troubles from irritation of the gastro-intestinal tract, and from the uterus and appendages, and recites illustrative cases. He explains their mechanism in such cases through the intervention of the vasomotor fibres of the sympathetic nerve, and sees no reason why these reflex influences may not, in certain cases, play the part of *direct* exciting causes.

In the discussion, Dr. Tansley observed that he had met with many cases of naso-pharyngeal catarrh in girls, fifteen to twenty years of age, who were anæmic and chlorotic, and who suffered from constipation. The association of nasal troubles with irritations of the stomach and gums was discussed by other members without eliciting any novel observation.

John N. Mackenzie.

"A. H. L."—The Successful Palliation of Hay Fever. *Med. News, September* 15, 1888.

TAKE $\frac{1}{200}$ grain atropine sulphate on rising, and repeat dose every four hours till bedtime. Should dryness of the nose continue longer than four hours the atropine may be withheld until renewal of the flow. If any dose fails to check running from the nose, it may be repeated in half-an-hour. Incipient dryness of the mouth indicates the limit to dosage. This should be combined with the local use of cocaine (from half to four *per cent.*). The author figures a cotton carrier for applying the latter, which he prefers to the employment of atomization.

John N. Mackenzie.

ARNOLD.—On Hairy Polypi of the Naso-Pharynx, and their Relation to the Teratomata. *Virchow's Archiv.*, 1888.

THE author reports upon a case of congenital tumour removed by a galvano-cautery loop. The author believes that these are autochthonous teratomata.

Michael.

CHOLEWA (Berlin).—**Hypertrophies of the Posterior Ends of the Lower Turbinated Bodies.** *Zeitschr. f. Ohrenheilk.*, Bd. XIX.

THE author reports upon 93 cases of this affection. He believes that these growths arise from stagnation following upon chronic catarrhs. The symptoms are frontal headache, feeling of occlusion of the nose, or of a foreign body. The hypertrophies are best removed with the cold snare.

Michael.

LARYNX.

SOLIS COHEN, J.—Cantatory Paresis. *Medical News, October* 6, 1888.

THIS is a variety of vocal disability, experienced only in singing, the voice remaining good in all portions of the register utilized in ordinary conversation. There is a lack in the precision of the tone as the point of failure in the scale is reached, and this is sometimes associated with an involuntary slide or a tremble. Prolonged effort, as in singing, is often fatiguing and often painful; the voice is quite unimpaired for conversation. The most frequent cause is over-fatigue of the intrinsic muscles of phonation from forced effort or from customary efforts made during impaired conditions of health. Faulty respiration in singing is the next most frequent cause. There is usually a lack of longitudinal tension of the vocal bands, and these are sometimes more or less undulatory in outline on the horizontal surfaces. The vocal bands are usually somewhat congested, in some instances with a pearlish translucence. Positive laryngoscopic evidence of atony may be absent, the character of the voice and the history of vocal fatigue remain the sole features in diagnosis. As to pathology, there may be slight congestion of the vocal bands or lack of due longitudinal tension, causing an elliptical glottis which does not close posteriorly with the rise in vocal pitch, and which is due to failure of contraction of the thyro-arytenoid, lateral crico-arytenoid and crico-thyroid muscles. Possibly, undue strain may stretch, or tear, or otherwise impair some of the delicate fibrillæ of the thyro-arytenoid muscles, which interferes with the adjustment of the vocal bands necessary to produce the tones at which failure occurs. Undue effort is then thrown upon other muscles to secure the necessary tension, producing fatigue and atony with irregularity in contraction and in phonal vibration of the vocal bands. Under proper treatment prognosis is good, but carelessness may lead to loss of the singing voice. The first element in treatment is absolute rest of the singing voice, the next is improvement of the general health. Strychnine, quinine and cocaine are most likely to be useful for the impaired muscles.

Systematic vocal exercises limited to the unimpaired portions of the register, and daily percutaneous applications of induction currents from one side of the larynx to the other assist in overcoming the muscular atony. Great care should be exercised in resuming prolonged vocal effort for a year or two after apparent cure has been effected, lest the condition recur in an aggravated form. R. Norris Wolfenden.

MERRIGAN, T. D.—Erysipelas of the Larynx; Intubation; Laryngotomy. *Med. Rec., October* 6, 1888.

A MAN, aged thirty-three, an Italian labourer, was attacked with erysipelas of the face and scalp, from which he made good recovery. A

month after it had disappeared from the scalp and face he began to complain of difficulty of swallowing, pain over the larynx, high fever, dysphagia, hoarseness, and enlarged glands at the angle of the jaw. Laryngoscopically it was seen that the epiglottis was much swollen and immovable, the aryepiglottic folds dark red and swollen, almost closing the glottis. The vocal cords could not be seen. Inspiration was loud and whistling, and there was a croupy cough, with expectoration of thick tenacious mucus. The symptoms becoming urgent, an O'Dwyer tube was inserted, but was expelled by vomiting. It was reinserted and retained. Breathing was easier. Morphia and brandy were given, and the tube retained all night. Next day it was expelled by coughing, and was not reintroduced. Temporary improvement occurred in the breathing, but at night symptoms were aggravated, and repeated attempts to introduce the tube failed, the swelling in the larynx having become so great. Laryngotomy was therefore performed. The next day the laryngeal swelling was greater, and there was slight redness of tonsils, uvula, and fauces. A fortnight after the patient was allowed out of bed, well, apparently, but for the laryngeal condition. Fetid pus was discharged from the trachea every time the tube was removed, and there were large granulations on the tracheal wound. Occasional severe dyspnœa occurred through plugging of the tube with mucus. A fortnight after this, while cleaning the inner tube, the patient seized the outer tube, tore it out, and fell back dead.

At the autopsy the lungs were found to be healthy; the cricoid cartilage necrosed and thin, and completely detached from the soft parts. There was great exudation into the epiglottis and aryepiglottic folds, which completely closed the glottis. **R. Norris Wolfenden.**

HOLLINGSHEAD, FRANCIS.—Perichondritis of the Larynx; Tracheotomy; Recovery. *Lancet, June* 9, 1888.

In this case anti-syphilitic remedies were administered. During its progress a piece of exfoliated cartilage was coughed up.

Hunter Mackenzie.

HUTCHINSON, P. S.—Acute Necrotic Perichondritis of the Larynx in a Pig.—*Brit. Med. Journal, September* 22, 1888.

It is sometimes denied that purely idiopathic perichondritis can occur in the human subject, and a specific origin is always sought for. The case here recorded is, therefore, very interesting, since such an origin must clearly be eliminated in the case of a pig. The inflammation in this case was most probably catarrhal. The onset was rapid; the animal's symptoms resembled croup. The cricoid cartilage was necrosed and exfoliated, and there was general œdema of the larynx.

R. Norris Wolfenden.

WINSLOW, RANDOLPH (Baltimore).—**Cut Throat.** *Maryland Med. Journ., July* 21, 1888.

An excellent clinical paper. **John N. Mackenzie.**

BARENDT, F. H. (Bootle).—**Fracture of the Larynx; Emphysema of the Neck; Laryngotomy; Death.** *Lancet, March* 3, 1888.

THE patient had, whilst playing football, received a violent blow over the windpipe from a man's elbow. There resulted stridulous breathing, with husky and painful speech, and blood-tinged sputum. Well-marked emphysema was present on both sides of the neck, especially the left, where crepitus could be elicited. Punctures of the emphysematous tissues were made, but the relief resulting was slight, and laryngotomy became necessary. It was now ascertained that the left ala of the thyroid cartilage was fractured, but not separated from its fellow. The patient progressed favourably at first, but afterwards became worse, and died of septic pneumonia (autopsy) on the fifth day after admission.

Hunter Mackenzie.

HOPMAN (Cologne).—**On Warty Growths (Papilloma) of the Respiratory Mucous Membranes.** *Volkmann's Vortrage*, No. 315.

THE author makes a report upon the cases of papilloma observed by him. Constant irritation, or chronic catarrhs, are the usual exciting causes of these neoplasms. They have a relation to syphilis. Such growths are very rare on the tracheal mucous membrane, and the author has only seen one such case, which occurred in a girl aged twenty-six, and who coughed out small growths, which were found to spring from the deeper portion of the trachea. The author records twenty-three cases of laryngeal papilloma, in twenty of which he had operated. Twelve of these operations were endolaryngeal, and eight required thyrotomy. Endolaryngeal methods should be preferred, where possible, in the author's opinion. The author has observed one hundred and twenty-three cases of papilloma of the pharynx, and two cases of nasal papilloma. The author believes that papillomata are benign growths, and transformation into malignant growths must be very rare. He himself has never seen such an occurrence.

Michael.

WISE, C. H.—Case of Successful Laryngotomy for Laryngeal Stenosis. Tube removed after Twelve Weeks' Wear. *Lancet, March* 17, 1888.

TERTIARY syphilitic disease was the cause of the stenosis. The author deems the case worthy of record "from the success of an operation performed *in extremis* and without any assistance, and from the fact that, contrary to the usual history of syphilitic stenosis of the larynx, the stenosis disappeared under treatment, and the tube could be safely dispensed with after three months' wear."

Hunter Mackenzie.

LE DENTU.—Total Ablation of the Larynx. *Gaz. des Hôp., July* 24, 1888.

THE case was one of malignant disease, for which this surgeon removed the whole larynx, employing the thermo-cautery only to separate a portion of the anterior wall of the œsophagus which was adherent to the neoplasm. The operation was easy, and the immediate results good,

but three months afterwards recurrence occurred, and death from cachexia soon followed. The author compares the results of this operation with tracheotomy, and quotes Hahn's statistics. He thinks that the results are apparently equal, but it is only just to say that one cannot judge definitely until we have a larger number of operations, and until these are undertaken at an earlier stage. **R. Norris Wolfenden.**

GARDNER, WILLIAM (Adelaide).—**Case of Total Extirpation of the Larynx for Epithelioma.** *Lancet, June* 23, 1888.

RECORD of a successful case. **Hunter Mackenzie.**

THORNTON, PUGIN.—On Tracheotomy Tubes. *Lancet*, April 7, 1888.

THE author describes and illustrates the various tubes in common use, and gives his opinion as to which is the best and most suitable form. This is stated to be Durham's right-angled ones. **Hunter Mackenzie.**

ZALESKI, ST. SZCZ. (Dorpat).—**The Unsuitability of Silver Tubes for Tracheotomy.** *Lancet*, April 28, 1888.

THE author remarks upon the solvent actions of the secretions of the trachea and bronchi on the silvers : this may be so marked as to change the tube into a mere shell, having the appearance of a kind of coarse cobweb. The greater part of the lost silver is absorbed into the system, with the consequent production of *argyria*—a grave and dangerous affection. In place of silver, the author recommends for wealthy patients gold, platinum, or rock crystal, and for the poorer classes porcelain, glass, or ivory. **Hunter Mackenzie.**

KIDD, PERCY (London).—**On Tracheotomy in Laryngeal Phthisis.** *Lancet, March* 31, 1888.

THE conclusion arrived at by the author is that stenosis is the only clear indication for opening the trachea in this affection. **Hunter Mackenzie.**

WRIGHT, E. A.—Case of Obstruction to Respiration. Tracheotomy. Ultimate Recovery. *Lancet, September* 29, 1888.

A BOY, aged twelve, caught a chill, and had rigors, temperature of 101°, dyspnœa, and brassy cough. The appearance of the throat from the mouth was normal. No retro-pharyngeal abscess could be found. The symptoms became worse, and paroxysms of dyspnœa dangerous. Tracheotomy was performed, and it was discovered that the obstruction was situated below, above the bifurcation of the trachea. A gum-elastic catheter having been introduced, the surgeon thought he had come upon a foreign body, and pushing it forcibly onwards there was a sudden gush of offensive pus from the tracheal wound, the breathing became easier, and the boy began to improve. The author thinks there could be little doubt that the condition was one of abscess, arising in one of the bronchial glands, pointing into the trachea, which was, fortunately, ruptured with the end of the catheter. The diagnosis in these cases must be arrived at through a process of exclusion.

R. Norris Wolfenden.

GRABOWER (Berlin).—**On Laryngeal Syphilis.** *Deutsch. Med. Woch.*, No. 38, 1888.

A CASUISTIC report from Professor Fraenkel's clinic. **Michael.**

HUMRICHOUSE, J. W. (Hagerstown, Maryland).—**Two Cases of Intubation of the Larynx.** *Maryland Med. Journ., March* 10, 1888.

DEATH in both cases. In one from catarrhal pneumonia; n the other from extension of the membrane to the bronchi. **John N. Mackenzie.**

THOMAS, E. (Geneva).—**Intubation of the Larynx.** *Revue Médicale de la Suisse Romande, June*, 1888.

INTUBATION, from its inconveniences, and from the real difficulties in the way of performing it, does not appear to the author likely to supplant tracheotomy, an operation which, though certainly not easy, requires less complicated instruments, can be practised more rapidly, is under control of the eye the whole time, and the subsequent care of which is less onerous. Of eleven cases, D'Heilly has only had two cures. The special advantages of intubation appear to the author to be :—(1) The absence of a cutting operation, which parents so often decline. (2) It allows the respiration of air which has been previously warmed in the mouth. These, however, are small advantages compared with the greater ones offered by tracheotomy. **R. Norris Wolfenden.**

CHAMBERS, J. W. (Baltimore).—**Seven Cases of Intubation of the Larynx.** *Maryland Med. Journal, February* 4, 1888.

SIX deaths and one recovery. **John N. Mackenzie.**

CURTIS, JAMES G. (Louth).—**Intubation of the Larynx for Diphtheria.** *Lancet, March* 31, 1888.

A SHORT note of the case of a boy who recovered from diphtheria with marked respiratory obstruction, after intubation. It is worthy of special notice that the tube was maintained in the larynx for twenty minutes only.
Hunter Mackenzie.

HAWKINS, CHARLES (London).—**Foreign Bodies in the Trachea.** *Lancet, June* 26, 1888.

THE author gives a detailed account of the case reported in the "Transactions of the Royal Medical and Chirurgical Society of 1843," by Sir Benjamin Brodie, in which, during an exhibition of conjuring, a half-sovereign fell into the trachea, from which it was expelled, after tracheotomy, by placing the patient in the prone position.
Hunter Mackenzie.

KILNER, WALTER J.—**Foreign Body in the Right Bronchus.** *Lancet, June* 23, 1888.

THE foreign body (a clove) is stated to have remained in the lung of a child 296 days; it was expelled, by coughing, in such minute portions as to render the microscope necessary for their detection. Severe pulmonary inflammation was followed by a somewhat tedious period of

convalescence, which, so far, appears to have ended in partial recovery only. The author believes that the symptoms were probably partly owing to malarial influences. **Hunter Mackenzie.**

NECK, &c.

OZENNE, E.—The Treatment of Tumours of the Thyroid Body. *Gaz. des Hôp., September* 29, 1888.

GENERAL medication is hygienic and prophylactic. Iodine is the only medicine useful internally, either under the form of iodide of potash or as tincture of iodine. The medication ought to be continued for a long time. Local medication consists in the application of various unguents and emplastra, of which one only appears to be of any use, namely tincture of iodine. Medical treatment is generally ineffectual in sporadic goître. The question of surgical intervention should be guided by the phenomena produced by the volume, nature, and course of the tumour. Palliative operations aim at remedying the effects of compression, especially of the respiratory tract. These consist of displacement of the tumour and tracheotomy. The former was performed by fixing a fork-like instrument in the tumour, and the other extremity to the thorax. The goître then contracted adhesions to the skin, on which cauterizations were repeatedly practised. Nine patients treated in this fashion yielded eight successes. Terrillon lately employed the same method favourably. Tracheotomy is often necessary. Luening related seven cases, in which tracheotomy alone not only relieved asphyxia but cured the condition. With regard to cystic goître, the seton, drainage, cauterization, incision, have each had their advocates as methods of producing suppuration in the cyst. Simple puncture and injection of irritants ought to be preferred, always remembering that this treatment is not free from danger, and that when there is no pressing contra-indication, methods which will not provoke suppuration should be chosen. As for parenchymatous goîtres, interstitial injections are the most efficacious, tincture of iodine being preferred by most surgeons; some cases being refractory, and, especially if old, require thyroidectomy. Preliminary tracheotomy is not necessary as a rule, and ligature of the thyroid arteries beforehand is often difficult to perform. The operations which can be performed are—total ablation, partial ablation, and enucleation. The first operation is not now considered physiologically justifiable. As to exophthalmic goître, surgical intervention is of recent date. Watson completely extirpated the thyroid in three cases. Benard related those successful from the practice of M. Tillaux. Ollier employed cauterization successfully. Graves' disease is, therefore, not a contra-indication to surgical interference. As for cancer of the thyroid, many surgeons (Holmes, Duplay, Lucke, Rose) refuse to

interfere unless signs of compression become urgent. Others (Wolffler, Billroth, Kauffmann) advise interference. Tracheotomy gives worse results than extirpations, and these patients always succumb rapidly. Thyroidectomy is not successful, recurrences occur, and are almost always fatal. **R. Norris Wolfenden.**

WHITEHEAD, WALTER (Manchester).—**The Surgery of the Thyroid.** *Lancet, March* 10, 1888.

THE author expresses a strong preference for excision of the thyroid in all cases where surgical interference is imperative, and condemns all less radical treatment, such as puncture and injection of irritating fluids.

In operating, the author warns the surgeon not to be misled by the thyroid muscles, which are found stretched over the gland, and very much altered in character. Carefully divide layer after layer of these, until the capsule is reached. The vessels are the best guide. Secure each vessel separately, and divide it between two ligatures. The thick attachments of the tumours ought to be thinned by a process of "teasing" with a blunt instrument.

When suffocative symptoms develop there are two ways of dealing with the tumour. The isthmus may be either divided or removed. The surgeon who is deficient in confidence may effect either of these by Paquelin's cautery.

The author refers to a case of sudden spontaneous resolution of a goître which came under his observation.

He has found exophthalmic goître recover under simple faradisation. To this end the sittings must be prolonged and numerous—half an hour each time, and repeated at least twice daily.

Special attention is directed to the fact that the recurrent laryngeal nerve passes behind the inferior thyroid artery, and is frequently injured during excision of the gland.

The treatment after excision is simply free drainage and immobility of the head for the first four days, the tissues being brought together by iron sutures and a large perforated rubber tube introduced.

Hunter Mackenzie.

WEBSTER, A. G. (Golcar), **and RUEL, ATKINSON T.** (Madley).—**Congenital Goître.** *Lancet, March* 17, 1888.

SHORT records of four cases in infants, in which breathing and swallowing were seriously interfered with. Spontaneous recovery or improvement took place in each case. **Hunter Mackenzie.**

WORTHINGTON, J. C. (Colorado).—**Congenital Goîtres.** *Lancet,* May 12, 1888.

A REFERENCE to a case which "was cured in a day by two applications (of an ointment composed of ten grains of mercuric biniodide to an ounce of lard), each application having been followed by immediate exposure of the anointed part to the sun, as recommended by Prof. Aitkin. The cure was complete and permanent." **Hunter Mackenzie.**

KIRK, ROBERT (Glasgow).—**Case of Tetanic Spasms in a Cretinoid Woman.** *Lancet, June* 16, 1888.

RECORD of a case (of myxœdema) which, in addition to presenting tetanic symptoms, principally affecting the muscles of the lower jaws, also exhibited the now well recognized hæmorrhagic tendency of the disease. **Hunter Mackenzie.**

DECRESSAC, M. E.—A Case of Hydatid Cyst of the Thyroid. *Gaz. des Hôp., September* 1, 1888.

THIS condition is very rare, and diagnosis has to be made from bronchocele, chronic prethyroid hygroma, and certain congenital cysts with deep attachments. Puncture of the cyst must be made, and simple cyst must be differentiated from hydatid. All internal medication or topical applications are useless, and the cyst must be emptied or ablated. Simple opening, washing and suture of the wall to the margins of the incision may be preferred in some cases. In this case Dr. Perrott performed ablation with excellent result. **R. Norris Wolfenden.**

TERRILLON. — Three Observations on Goître, Interglandular Enucleation, and the Method of Luton. *Prog. Med., October* 13, 1888.

THE first case was one of old goître, polycystic, and with partial calcareous degeneration, and which was enucleated. The second was also one of parenchymatous goître, also enucleated; and the third was one of parenchymatous goître of recent origin, cured by injections of iodine. In the course of an interesting review of the different methods of treating goîtres, the author remarks that injections of iodine are only suitable for recent cases. The operation of enucleation, which the author has performed, is that of Socin, which differs materially from that of Juillard, and also from Kocher's operation, in that it respects entirely the healthy parts of the gland. Socin's operation can be performed in all cases in which it is necessary to operate upon the gland. The cases in which the operation is contra-indicated are—1, diffuse hypertrophies of the whole gland; 2, malignant tumours; 3, goîtres, with very many multiple nuclei. No other method is entirely free from the possible complication of cachexia strumipriva. Socin's operation is, however, quite free from this possibility. Luton's method of the injections of iodine, which is suitable for recent cases of goîtres of diffuse hyperplasia and soft consistence, and for those with multiple nuclei, and Socin's operation suitable for the majority of goîtres, are, according to Terrillon, the only justifiable methods of treatment. **R. Norris Wolfenden.**

TAYLOR, J. M. (Phila.).—**On the Early Recognition of Exophthalmic Goître (Graves's Disease).** *Maryland Med. Journ., March* 28, 1888.

REPORT of eight cases with remarks. Although valuable clinically, the paper contains no altogether original observation. **John N. Mackenzie.**

ROCKWELL, A. D. (New York).—**Basedow's Disease.** *New England Med. Monthly, September*, 1888.

A GOOD clinical lecture. The formula which (supplementary to the galvanic current) the author has found of greatest value is as follows :—

℞ Ferri pyrophosphat,
Zinc bromid. ... ... aa. ʒi.
Tr. digitalis ... ... ʒv.
Ext. Ergot. fluid.... ... ʒiv.
M

Sig. Teaspoonful twice or three times a day.

The objection to this is its vile taste, and in cases which reject it, its equivalent in pill form may be substituted for the liquid preparation.

John N. Mackenzie.

REPORTS OF SOCIETIES.

American Rhinological Association.

Sixth Annual Meeting, Cincinnati, Sept. 12, 13, *and* 14, 1888.

President : DR. C. H. VON KLEIN.

THE following papers were read :—

1. *Chorea of the Soft Palate caused by Hypertrophy and Hyperæsthesia of the Mucous Membrane, covering both Inferior Turbinated Bodies.*—By DR. J. E. SCHADLE, of St. Paul.

A CASE was related of constant contraction and relaxation of the levatores palati, during which the uvula was carried upwards and backwards until it touched the pharynx, and the action caused a loud sound like the rapid tick of a watch. This occurred in a young lady in otherwise excellent health. Enlarged tonsils were found to be present, with evidence of throat and nasal disease. There was frequent constipation and flatulence, and excited cardiac action, especially upon exertion. Distinct rhythmic choreiform movements of the velum palati were found on inspection, with chronic hypertrophy of the turbinates (inferior, and less so, of the middle bones). The hypertrophy was removed with Cohen's post-nasal cutting forceps and the electric cautery, and the choreiform movements then disappeared for two weeks, when they suddenly returned under the influence of a spell of nervous excitement. Cocaining the intra-nasal passage produced relief for half-an-hour. The hypertrophy of the turbinated bodies was reduced by burning them with the electric cautery, and the trouble at once ceased, when breathing was restored through the nose, and the dry condition of the pharynx was relieved. The functional trouble of the heart and the shortness of breath previously complained of also disappeared, and the patient was permanently cured.

2. *The Etiology and Pathology of Nasal Diseases.*—By DR. T. F. RUMBOLD (St. Louis).

THE author had long been convinced that heredity was wrongly considered to be a cause of disease.

3. *The Influence of Morbid States or Conditions of the Body on Local Diseases.*—By DR. H. CHRISTOPHER (St. Joseph, Mo.).

PREDISPOSING conditions were—1. Diatheses, with local malignant manifestations. 2. Constitutional tendencies attended or not with local morbid action, *e.g.*, struma, rheumatism. 3. Constitutional disturbances affecting the function of

certain organs, which in turn gave rise to morbid action in others. 4. Abnormal action or derangement of function of certain organs, giving rise to morbid actions in other organs, *e.g.*, metastases, or functional disorder of the heart in digestive disturbances. 5. Purely local morbid action. All these states, except the first and last, were often found to coexist with local nasopharyngeal and aural inflammations.

4. *The Effect of Nasal Inflammation on the Mind.*—By Dr. Rumbold.

A patient with a cold in the head had the mental powers lowered. It follows that if an acute inflammation in the nose can excite mental manifestations, chronic rhinitis must bring about severe mental incapacity.

5. *The Relation of Nasal Diseases to other Diseases.*—By Dr. John North.

Neurasthenia was often the result of chronic nasopharyngeal troubles. The author considers catarrh or rhinitis not as an inflammation, but a condition caused by paresis of the sympathetic ganglia of these regions. Asthenia was due to vasomotor paresis, causing dilatation of vessels. Many diseases arose by the influence of one organ being exercised upon another by the intervention of the sympathetic system, and asthma and hay fever have been shown by many observers to depend upon diseased conditions of the nasal cavities.

6. *The Etiology and Pathology of Acute Catarrh.*—By Dr. J. G. Carpenter (Stanford).

The most prominent causes were occupations in which much dust, smoke, excessive moisture, dry dusty atmosphere, insufficient clothing were present.

7. *Intra-nasal Obstructions.*—By Dr. R. S. Knode (Fort Wayne).

These might be temporary or permanent. The former was usually the result of some one of the forms of rhinitis, and was to be treated with proper hygiene. When repeated colds left a pale, flabby, wrinkled condition, resembling mucus polypus, filling up the nasal cavities, he found 1 per cent. of cocaine most serviceable, followed by mild stimulating solutions of chromic acid (10 grains to the ounce), to be followed by vaseline. If stenosis returned a second application might be used, or slippery elm plugs, slightly moistened with cocaine and listerine, be applied.

8. *A Case of Enlarged Tonsils, with Peculiar Symptoms, Relieved by the Galvano-Cautery Snare.*—By Dr. E. G. Kegley (Cedar Rapids).

The symptoms occurred in a man of forty-three, and consisted in excessive lachrymation, red and swollen eyes, constant flowing from and wiping of the nose, great congestion of the nasal mucous membrane, and the mouth constantly filling with saliva. The tonsils were enormously large. These attacks would occur very commonly, and would last one or two weeks. In the intervals the nasal mucous membrane was normal. After removal of the tonsils with the galvano-cautery snare the man was cured, and had remained so since.

9. *The Surgery of Gummatous Growths of the Nasal Cavities.*—By Dr. A. G. Hobbs (Atlanta).

A young married woman, who had had syphilis for three years, suffered from stenosis of the nasal passages. A purplish red growth filled the right nasal space completely and pressed into the left cavity till stenosis was nearly complete. A course of iodide of potassium and biniodide of mercury for four weeks was not followed by improvement, and the growth was therefore cut away with a cutting spoon. Very little hæmorrhage occurred. Four sittings were necessary to remove the growth. It sprang by a broad pedicle from the posterior part of the septum. No ulceration followed, and six months after the operation the patient regained her health completely.

The author reported four cases.

10. *The Surgical Treatment of Nasal Catarrh.*—By DR. A. B. THRASHER. THE cases requiring surgical aid were those due to mechanical obstructions, hypertrophies, neoplasms, &c. There were cases in which the application of a chemical caustic would reduce enlargements of the turbinated body. The author had had most success with the galvano-caustic knife.

The officers for 1889 were appointed :—

DR. JOHN NORTH, President.
DR. A. G. HOBBS, DR. A. B. THRASHER, } Vice-Presidents.
DR. R. S. KNODE, Secretary and Treasurer.
DR. N. R. GORDON, Librarian.
DR. HIRAM CHRISTOPHER, DR. J. G. CARPENTER, DR. THOS. F. RUMBOLD, DR. J. G. SINCLAIR, } Members of the Council.

Chicago was voted as the next place of meeting.

Congress of American Physicians and Surgeons.

September, 1888.

Dr. W. H. WELCH read a paper reporting the *Results of Experiments relating to the Thyroid Gland of the Dog.*

EXTIRPATION of both lobes was uniformly fatal in from two days to three weeks. The author's experiments disproved the statements of Munk that the fatal result is not due to loss of the thyroid gland, but is referable to some undefined injuries attending the operation of removal. Extirpation or isolation of one lobe only is followed by full recovery of the animal, without any of the symptoms which accompany full extirpation. In the lobe remaining an increase of size took place, the epithelial cells of the follicles increased in size and number, the lumen was diminished in size and irregular in shape by the epithelium forming plicate folds, and in these masses new capillaries were formed. In some places these masses and capillaries occupied the situation of the original follicles. These changes would so alter the structure of the gland that two months after the operation it would not be recognized microscopically as belonging to the thyroid. The colloid substance disappeared, and in places enormous dilatation of the capillaries took place. These changes, which were of the nature of a return to the embryonic condition, might be interpreted as compensatory hypertrophy. In seven or eight cases out of fifty unilateral extirpations death occurred within a month without any explicable reason, the animals becoming weak and cachectic, often exhibiting ulceration of the gums, and in two cases convulsions. In two cases after ligation of everything entering the two lobes of the gland except the main artery and vein, changes were found similar to the hypertrophic ones, both cases exhibiting symptoms like those of total extirpation. The experiments were performed by Dr. W. S. Halsted, at the John Hopkins University.

Dr. JACOBI read a paper on the *Pathology of the Thymus Gland.*

THERE is no ascertained size of the gland of the thymus. He admitted that its hypertrophy might have some obscure connection with laryngismus stridulus, as there were cases in which the sudden death of infants might be best explained by hypertrophy of this gland. He alluded to inflammations and suppurations of the gland, and hæmorrhages, also to malignant growths, of which endothelioma, lymphoma, fibroma, sarcoma, carcinoma and myxoma have been described. Most of them are doubtful as it could not be proved that they may not have

arisen in the thyroid or in some neighbouring lymphatic gland. The author has studied in detail the pathology of tuberculosis of the thymus. In most cases the bacillus was found in the walls of the arteries and arterioles, and the lumen of the vessels was the seat of obliterating change. Syphilis results in two changes, both in the accumulation of hyperplastic connective tissue, and in one case in the formation of a gumma. Diphtheria results in general parenchymatous degeneration. In a case of persistent thymus found in a man aged twenty-six, retrograde metamorphosis was in full progress, the parenchyma being in a condition of fatty degeneration, and the stroma being replaced almost entirely by fat.

The American Surgical Association.

September, 1888.

Dr. GEORGE W. GAY read a paper entitled, *The Comparative Methods of Tracheotomy and Intubation in the Treatment of Croup.* (This paper is abstracted at page 413.)

DURING the discussion, Dr. H. H. MUDD said that intubation had been done as a precaution in many cases in which tracheotomy would not have been thought of, and some of the good results of intubation are to be attributed to this fact. In most of his cases of intubation where the patient survived, he had had to resort to tracheotomy, and patients have recovered from tracheotomy where intubation has been unsuccessful.

Professor ANNANDALE spoke of the value of introducing the tube through the glottis in cases of operation about the throat, where there was risk of suffocation or of hæmorrhage into the trachea.

Dr. HUBER has had thirty-seven recoveries out of ninty-four cases of intubation. He does not operate early, and considers internal use of bichloride of mercury as of equal importance as intubation. It is advantageous sometimes to use a small tube, with the expectation that it may be coughed out, and with it a portion of membrane, affording an opportunity for feeding when the tube is out.

Dr. T. F. PREWITT had in one case of diphtheritic paralysis passed a catheter through the glottis and plugged the larynx with a sponge. This permitted fluid to go into the œsophagus without entering the trachea.

THERAPEUTIC NOTES.

SOZOIODOL.

This drug, which has recently been introduced by the firm of H. Trommsdorff, of Erfurt, is a compound of iodine, sulphur, and carbolic acid. Chemically, it is an iodated-phenyl-sulphonic-acid, and contains about 52 per cent. of iodine, 20 per cent. of carbolic acid, and 7 per cent. of sulphur. It was really discovered some years ago by Professor Wagner, of San Francisco, and was employed in the treatment of skin diseases, but was abandoned on account of its too irritating properties. As now prepared, however, it is pure, and has lost these bad qualities. It has been very highly spoken of in the treatment of various throat complaints, such as nasal and naso-pharyngeal chronic disorders. Hopmann and Fritsche have both recommended it highly for laryngitis sicca, rhino-pharyngitis, hypertrophic pharyngitis, ozæna, syphilitic conditions of the mouth and nose, and in tubercular ulceration of the larynx. Larmuth, writing in the *Manchester Medical Chronicle*, has confirmed those favourable statements.

The preparation may be used either as an insufflation or in solution, and the salts to be employed may be the potash, the sodium, the zinc, or the mercury salts. The former may be simply dusted over the affected surface, or may be employed in watery solution of 5 to 10 per cent. Insufflations may be made by mixing with talc or milk sugar. The mercury salt should be employed in this manner.

VAPOROLES FOR INHALATION.



Messrs. Burroughs & Welcome have manufactured at our suggestion small capsules, containing each the necessary quantity of medicament to be employed in inhalation. This will be of great service in prescribing for private patients, obviating for the future the necessity of giving the ordinary medicine bottle. This well-known firm has spent much effort in endeavouring to perfect the method in conjunction with us, and the result is a very elegant means of prescribing inhalations. These are, perhaps, more extensively used in this country than elsewhere, and the pharmacopœia of the Throat Hospital contains a large number of such preparations, most of which are of great use. The list of those prepared by Messrs. Burroughs & Welcome is as follows:—

1. Vaporole Benzoini.
2. Vaporole Pini Sylvestris.
3. Vaporole Juniperi.
4. Vaporole Calamis Aromatici.
5. Vaporole Chloroformi.
6. Vaporole Cubebæ cum Limone.
7. Vaporole Creosoti.
8. Vaporole Thymolis.
9. Vaporole Terebenis.
10. Vaporole Acidi Carbolici.
11. Vaporole Iodi.
12. Vaporole Eucalypti.

The manufacturers have proposed to call these capsules Vaporoles. In using them for inhalation, the capsule is first crushed, and then dropped into the inhaler. Each capsule is protected by a thin layer of cotton-wool, and enclosed in a silk cover. They are most elegant in appearance, and, from their small size, are most portable. The dose of the essential-oil to be inhaled is, in all cases, that prescribed in the Throat Hospital pharmacopœia. We are greatly indebted to this well-known firm for working out our ideas to such great perfection, and we feel sure that these vaporoles will be of great service to the physician as well as to the patient.

CREOLIN.

This is a product from coal tar, possessing valuable antiseptic properties, and is being extensively used in the treatment of throat and nose complaints at present on the continent, and more especially in Vienna, where it has received special commendation from Professor Schrotter, and has been largely used in surgical and gynæcological practice. Bateriological experiments have proved that a 5 per cent. solution of creolin is sufficient to destroy all micro-organisms, while only a 3 per cent. solution is effective enough to produce the same result in one minute. The solutions are, moreover, entirely harmless to sound tissues. This disinfectant action of creolin is only surpassed by corrosive sublimate, and it is incomparably more active than carbolic acid. It is also said to possess a certain styptic action. A 5 per cent. solution produces a slightly burning sensation when brought into contact with the skin, but this soon passes off. The odour of creolin is not very pleasant, but this is counterbalanced by its cheapness and effectiveness. Creolin is quite harmless when taken internally, and though its therapeutics in this respect have not been yet determined, it is worth noticing that Spaeth observed a marked decrease of flatulence after doses of 12 grains, and entire suppression of intestinal gases after doses of 22 to 90 grains.

It is thus quite equal to naphtholin. Doses of 120 grains do not produce disagreeable after-effects. 1 per mille of creolin is said by von Esmarch to entirely deodorise foul smelling solutions; and the same experimenter confirms the very favourable report of Eisenberg as to the antiseptic value of the preparation. It is used for bandages and surgical dressings just as carbolic acid is used, and it appears to promote granulation in a remarkable manner. It is preferred to both iodoform and corrosive sublimate by those who have used it extensively. The substance as sold is a pungent tarry liquid, mixing with water in all proportions, to form a milky emulsion. It is also soluble in alcohol. Since trustworthy experiments exist to show that creolin is superior to carbolic acid in all the properties which make it valuable in surgical practice, and since, moreover, it is so cheap and so devoid of harmful properties, it deserves to be extensively used in laryngological and rhinological practice.

NEW PREPARATIONS.

JEYES' SANITARY COMPOUNDS.

We have received from this firm a number of samples of the preparations introduced by them, the basis of all these compounds is Creolin, and we have given a short account of this important body in another place, see pp. 433-4. The introduction of this body as a disinfectant is an important advance, and we predict for the Jeyes' Sanitary Compound a very general popularity both in surgical and for general use. Very careful scientific experiments have been undertaken, which prove the great value of these compounds for sanitary and disinfectant purposes.

COCA WINE (Armbrecht, Nelson, & Co.'s).

Several preparations of coca wine have been placed before the public, but we unhesitatingly accord to the above the first place. Their wine is more suited to the English palate than some of the Continental preparations, which are too sweet to be palatable, and which destroy their otherwise tonic and invigorating qualities by deranging the digestive system or creating nausea. The value of coca wine in conditions of debility is too well recognized to require comment, and we need do no more than say that after a very careful trial of Messrs. Armbrecht, Nelson and Co.'s wine, we can speak most highly of it as a sound and invigorating tonic, and can recommend it most unhesitatingly.

SOZOIODOL (Mr. F. Boehm's).

We have on a previous page referred to this new preparation, and need only say that after a short experience of it in treatment of throat and nasal conditions, we consider that the salts of sozoiodol deserve to be extensively used in these conditions. They have already achieved a well-deserved reputation.

NOTES.

British Laryngological and Rhinological Association. — The first general meeting of the Association will be held on Wednesday, November 14, 1888, at the Langham Hotel, London. The following gentlemen have promised to read papers :—Dr. Hunter Mackenzie (Edinburgh), Dr. John M. Hunt (Liverpool), Dr. Greville MacDonald (London), Dr. Gordon Holmes (London), Dr. Dundas Grant (London), and Dr. Norris Wolfenden (London). There will be an exhibition of instruments and appliances used in the diagnosis and treatment of desases of the Nose and Throat.

CONTENTS.

Original Articles, p. 435.—Malignant Disease of the Upper Air-Passages, by G. HUNTER MACKENZIE. Syphilis of the Larynx, Trachea, and Bronchi, by J. SOLIS-COHEN.

Therapeutics and Diphtheria, p. 447. LICHTWITZ: on Creolin. BEEHAG: Menthol. COUPARD: Gelosine. GUINIER: Sulphur in Laryngeal Phthisis. DE CRESANTIGNES: Etiology of Diphtheria. LA PEYRE: Epidemic of Diphtheria. QUELPA and BLEYNIE: Treatment of Diphtheria. HUGUENIN: Diphtheritic Myocarditis.

Mouth, Tonsils, Œsophagus, etc., p. 449.—NETTER: Streptococcus in the Saliva. VALUDE: Tuberculosis of the Salivary Glands. LANG: Salivary Fistula. TRENGRUEBER: Cancer of the Mouth. RECLUS: Leucoplasia and Cancroid of the Mouth. CAZENAVE: Glossodynia. KIRMISSON: Cancer of Tongue. SEIFFERT: Rare Reflex Neurosis. OUSPENSKI: Hypertrophy of Tonsils. BALME: *Ibid.* GALLIARD: *Ibid.* WERNER: Hæmorrhage from use of Galvano-Cautery. DUCHESNE: Spasm of Pharynx. SPRENGEL: Retro-pharyngeal Abscess. TSCHARMER: Dysphagias and Disease of Bronchial Glands. SUAREZ: Foreign Body in Œsophagus. SCHWARTZ: Strictures of Œsophagus. KIRMISSON: Permanent Catheterism of Œsophagus. RUPPRUCHT: Case of Œsophagotomy. NICAISE: Gastrotomy.

Nose and Naso-Pharynx, p. 453.—ANNANDALE: Appliances for Fracture. SCHMIEGELOW: Purulent Discharges, and Empyema of the Sinuses. LACOARRET: Treatment of Catarrh. DE CRESANTIGNES: Epistaxis and Hysterical Mutism. MCBRIDE: Empyema of the Antrum. MCBRIDE: Treatment of Nasal Polypi. LE DENTU: Elephantiasis. SYMINGTON: The Eustachian Orifice.

Larynx, p. 454.—EXNER: Innervation of the Crico-Thyroid. JELENFFY: Anatomy, &c., of Laryngeal Muscles. CHARCOT: Tabetic Crises. AUFRECHT: Casuistic Communications. FORT: Ablation of Larynx. SCHMID: Total Extirpation of Larynx. THOM: Tracheotomy. BRAUN. Fibroma. MACKENZIE: Endolaryngeal Operations. BESCHORNER: On Ventriloquy. CASTEX: Cancer of Larynx. DARIER: Syphilis and Pachydermia Verrucosa. GAREL: Specific Perichondritis, Œdema, and Polypus. GOUGENHEIM: Syphilis and Tuberculosis. LARRANZA: Laryngeal Rheumatism. MOURA-BOUROUILHOU: Theory of Voice. GAREL: Spasmodic Cough and Chloride of Methyl. NALTIER: Hysterical Mutism. PLAYFAIR: Pin in Left Bronchus.

Neck, p. 459.—STORCH: Cystic Lymphangioma. SPRENGEL: Extirpation of Cystic Goitre. JACCOUD: Exophthalmic Goître. HUNTER: Specialism in General Practice.

Society, p. 460.—Edinburgh Medico-Chirurgical Society.

Reviews, p. 460.—GRÖNBECH: Naso-Pharyngeal Polypi. ROUGIER: Diseases of the Larynx.

Report of the Proceedings of the British Laryngological and Rhinological Association, p. 462.

Sore Throat.

LONDON.] DECEMBER. [1888.

TIMELY DRUGS.

It is often remarked by practitioners that the care of the throat receives too little attention, and that in health it should be gargled and cleansed very much more frequently than it is. Especially is this the case when there is a bad taste in the mouth in the morning, showing that the liver and digestive organs are a little out of order, and consequently the mucous membrane of the throat is more prone than ever to be the seat of disease. Many a case of consumption appears to start with some throat trouble, such as a dry cough, hacking, irritation, slight expectoration, or a weak voice. We are told that one of the most agreeable and cleansing gargles to use when arising in the morning is Hazeline diluted with several parts of water. It soothes and allays any irritation, cleanses the pharynx and mouth, sweetens the breath) and is in every way agreeable to use.

An agent that for many and many a year has enjoyed a deservedly high reputation for sore throat is Chlorate of Potash. In all the list of remedies there is no drug which exerts a more wholesome action in proper cases than this; but to obtain the beneficial action in its fullest measure it should not be employed, as is so frequently the case, in the form of gargles, where it is greatly diluted.

The best form of Chlorate of Potash to use is the Tabloids, which are composed simply of the pure drug compressed into bi-convex discs. They are free from admixture of every kind. In this respect they are most superior to lozenges, for in the latter the medicine is weakened in its action by gums, sugar, and flavouring matters. The Tabloids are very hard and dissolve slowly in the mouth, and in using, the oral and pharyngeal membrane is bathed continuously with a concentrated solution of the Potash Chlorate. Imitations of the Tabloids are made not only with inferior products, but so that they chip or crumble, and in the mouth too quickly fall to pieces. With them, as with gargles, the action falls short of what is required, the effect being momentary or at least too transitory. The hard Compressed Tabloids dissolve so very slowly that one remains in the mouth a considerable time, and a more prolonged action is obtained than would otherwise be possible with the same quantity of drug. Chlorate of Potash is used with success as a preventive of sore throat, and eminent laryngologists assert that its continued use in the incipiency of acute pharyngitis will frequently abort the disease. In simple as well as mercurial stomatitis; in aphthæ as well as syphilitic sore mouth; from a disease so simple as thrush, to one portending such evil as cancrum oris, the drug is relied upon with confidence as possessing unquestionable utility. The same is the case in ulcerative sore throat, tonsillitis, and even diphtheria. Going farther down, we find that even in enervated conditions of the larynx, where the voice is more or less husky, weakened or otherwise impaired, it is very good. It is beneficial to speakers and singers, who tell from actual personal experience of its value to them.

With the Tabloids the maximum effect is obtained with the least possible amount of the drug, and what is a matter of no trivial moment is that they may be used constantly with safety. So much can hardly be said of the imitations and gargles. Where it is designed to supplement the action of the Chlorate of Potash, the Tabloids of Chlorate of Potash with Borax may be employed.

Borax has an especially soothing, tonic action upon the mucous surfaces, liquefying tenacious mucous agglutinations, and differing from many agents in that it removes accumulated secretions by a liquefying and grateful, instead of an irritating, action. Where there is considerable mucus secreted, therefore, these Tabloids would probably answer better than the Chlorate of Potash alone. In all those multiform disorders of the throat affecting the voice, the parts must be treated in such a manner as not subsequently to weaken them. The Voice Tabloids contain, in addition to Chlorate of Potash and Borax, a very small quantity of Cocaine, just sufficient to act with requisite power. Cocaine preparations for the throat are, as a class, a most reprehensible and deleterious set of products, and should be discarded, if for nothing else, because they contain *large doses* of the drug, the effect of which is to produce congestion. Many a throat and voice have been greatly damaged by Cocaine. But with full truth and confidence it may be said of the Voice Tabloids—that they are perfectly safe.

The frequent and most troublesome form of throat affections is that where the parts seem a little weak. There is insufficient tone. It may be, perchance, the weakness is from over-speaking or over-singing. It is most commonly met with in those who depend largely for their livelihood upon the voice, so that perfect restoration of tone is all the more imperative. Many remedies may have been tried in vain. Those with great experience aver that the action of the Chloride of Ammonium Tabloids in such cases is perfect, and doubtless it is for its action in this class of cases that the Vereker Chloride of Ammonium Inhaler finds the chief source of its high reputation.

Voice Tabloids supplied to the Medical Profession in packages of 30 and 80, at 8s. 6d. and 16s. per doz. Retail price, 1s. and 2s. each.

Potash Chlorate and Potash Chlorate with Borax Tabloids supplied to the Medical Profession in packages of 40 and 100, at 4s. and 8s. 6d. per doz. Retail price, 6d. and 1s. each.

BURROUGHS, WELLCOME, & CO., Snow Hill Buildings, LONDON, E.C.,

Will be happy to supply trial Specimens to Medical Men free on request.

THE
JOURNAL OF LARYNGOLOGY AND RHINOLOGY.

VOL. II. DECEMBER, 1888. NO. 12.

Contributors of original articles receive Fifty Reprints gratis.

The Editors do not hold themselves responsible for opinions expressed by contributors.

MALIGNANT DISEASE OF THE UPPER AIR-PASSAGES.

By G. HUNTER MACKENZIE, M.D.

(*Continued from page* 291.)

CANCEROUS disease of the trachea is of very rare occurrence—Morell Mackenzie[1] is acquainted with two cases only, one of which was described as a soft cancer, and the other was an epithelioma. He refers to a case of Langhans[2]—the only example previously published—in which post-mortem examination revealed carcinoma of the mucous membrane of the trachea above the bifurcation. The disease appeared to have originated in the glandulæ of the mucous membrane.

Since the publication of Sir Morell Mackenzie's work (1880), a few more cases of malignant disease of the trachea have been recorded. Virchow[3] has demonstrated a case of tracheal cancer, and Gerhardt[4] showed before the Medical Society of Berlin a specimen of carcinoma of the trachea, taken from a patient aged thirty-eight years, who for two years had suffered from dyspnœa and hæmoptysis. The disease presented the appearance of a reddish tumour under the fifth tracheal ring.

Very few examples of tracheal sarcoma have been recorded in medical literature. The only cases known to the writer are those of Schrötter,[5] Zeman,[6] and Chiari.[7]

Several cases of malignant disease of the thyroid gland have been placed on record. These often extend to the trachea, which is thus affected secondarily. Thus Webster[8] mentions a case of malignant disease of this gland, which subsequently implicated the trachea, the larynx, and the cervical glands. The tracheal rings may be softened and the trachea

1 *Diseases of the Throat and Nose*, vol. i., p. 528.
2 *Virchow's Archiv.*, liii., p. 470.
3 *Berliner Klin. Wochen.*, No. 49, S. 933. 1887.
4 *Journal of Laryngology and Rhinology*, vol. ii., p. 90.
5 Referred to by Sir Morell Mackenzie. *Op. cit.*, p. 530.
6 *Journal of Laryngology and Rhinology*, vol. ii. p. 180.
7 *Ibid.*
8 *New York Medical Record*, February 28, 1885.

compressed, as in a case reported by Peyrot[1]; but this is not always the rule, for Metaxas[2] records an example of malignant tumour of the thyroid (sarcoma) which involved the skin and deep vessels, but did not soften the tracheal rings, although these were closely incorporated with the tumour. The disease may extend downwards into the chest, as in Norman Moore's[3] case of primary carcinoma, where invasion of the upper border of the aortic arch took place. In a case designated as one of "infiltrating tumour of the thyroid gland," Bowlby[4] says the tumour could not be defined on account of its infiltration of the neighbouring tissues. The nerves, arteries, and veins of the neck were implicated, the trachea was compressed all round, the aorta and its branches to the neck were incorporated in the new growth, and the apex of the left lung adhered to it. It appeared to be of the nature of a sarcoma.

Thyroid cancers may be primary, may be metastatic, or may supervene on some previous affection of the gland. Metastatic affections are not common, for Gross,[5] in 423 cases of metastasis in cancer of the breast, found in eight only, or 1·8 per cent., that the thyroid was the seat of the metastasis. A case of malignant disease of the thyroid occurring in the course of myxœdema of four years' duration has been reported by Gulliver,[6] and one of sarcoma supervening on an old goître of thirty years' standing, and growing into the trachea and compressing the œsophagus, has been recorded by Stephen Paget.[7]

Hadden[8] has seen in a case of myxœdema that the thyroid gland ultimately became involved in a new growth lying in front of it, and Shattock[9] mentions a case of sporadic cretinism in which the thyroid gland underwent malignant changes.

The situation, relations, and functions of the thyroid gland determine a greater width and variety of symptoms in malignant disease than obtain in cancer of the larynx or trachea. Thus extension of the disease may not only take place to the larynx, trachea, and gullet, but the bronchial glands, the pleuræ, the lungs, and the interthoracic blood-vessels may be affected by direct continuity. Metastases *from* the thyroid centre in malignant disease appear to be very common. Almost every organ may be affected, such as the neighbouring glands, the brain, kidneys, liver, lungs, bones, &c. The symptoms attendant upon the disease are liable to be modified, not only by the nature and degree of these extensions and metastases, but also apparently by the disturbance in the peculiar functions of the gland excited by the disease. Thus Roth[10] instances a case of carcinoma of the thyroid gland, accompanied by delirium and attacks of vertigo, which he believes to be due to destruction of the gland, and to be analogous in this respect to cachexia strumipriva.

1 *Société de Chirurgie de Paris*, December 23, 1885.
2 *Revue Méd. Francais*, No. 49, 1884.
3 *British Medical Journal*, May 8, 1886.
4 *Lancet*, December 6, 1884.
5 *International Journal of the Medical Sciences*, March, 1888.
6 *British Medical Journal*, March 6, 1886.
7 *British Medical Journal*, October 23, 1886.
8 *British Medical Journal*, December 5, 1885.
9 *Ibid.*
10 *Münch. Med. Wochen.*, No. 10, 1888.

In addition to the larynx, trachea, and thyroid gland, and apart from direct extension of disease from these localities, malignancy may originate and manifest itself in various contiguous structures. The hyoid bone may be affected, as in a case recorded by Verneuil,[1] in which it is worthy of note to observe that after death enormous cancerous masses were found in the lungs, without having given life-manifestations of their presence. The term, "Strangulating Cancer of the Neck," has been applied to a slow, diffuse, scirrhous infiltration of the cervical cellular tissue, which leads to strangulation of the most important tissues of the neck. It was first described by Volkmann. A case is recorded by Morris and Lawson.[2]

Malignant cysts of the neck are occasionally met with. Thus Treves[3] records four cases, partly primary and partly secondary, consisting of large smooth cysts, which originally contained a clear fluid, and the walls of which were either carcinomatous or epitheliomatous. After puncture the fluid became sero-purulent, purulent, and finally hæmorrhagic. Buthie[4] mentions a case that occurred to him in which a similar cyst was removed from a patient who previously had been operated on for cancer of the tongue. In this instance a lymphatic gland had apparently been affected, and its egress stopped, with the result that accumulation of secretion had occurred. Silcock[5] has reported three cases of cystic epithelioma of the neck. They all occurred in men from thirty-two to sixty-four years of age. On autopsy the cyst wall was found covered with a large number of papillomatous-looking growths, which the microscope showed to have all the characters of malignancy. Lejars[6] mentions an example of cystic epithelioma of the left upper hyoid region, followed by ulceration of the facial artery, and necessitating ligature of the common carotid. Rushton Parker[7] demonstrated before the members of the Liverpool Medical Institution a case of a "branchiogenic epithelioma" of the neck in a man fifty-six years of age, which had not returned after extirpation eight months previously.

Maylord[8] has recorded a case of lympho-sarcoma of the neck in a child four years old. The disease commenced as a little knot under the ears, and spread to the other side, without affecting the larynx.

1 *Gazette des Hôpitaux*, No. 74, June 24, 1884.
2 *Medical Press and Circular*, October 29, 1884.
3 *British Medical Journal*, October 23, 1886.
4 *Ibid.*
5 *British Medical Journal*, March 19, 1887.
6 *Progrès Méd.*, July 16, 1887.
7 *British Medical Journal*, January 10, 1885.
8 *Glasgow Medical Journal*, May, 1887.

SYPHILIS OF THE LARYNX, TRACHEA, AND BRONCHI.

By J. Solis-Cohen, M.D.[1]

(*Continued from page* 399.)

Symptomatology.—The laryngeal symptoms of secondary syphilis are not characteristic. They are chiefly comprised in dissonant alterations of the voice, either hoarseness, dysphonia, or in some cases occasional or temporary aphonia. The hoarseness is supposed to have some peculiarity which has been termed *raucedo syphilitica*, but this is not the case. In some instances it is simply due to the catarrhal laryngitis, in others to paresis of one or more of the constrictor muscles, or possibly to paralysis of the tensors. Respiration is not affected except in those instances in which œdema occurs in such a position as to occlude the passage for air, when it will be announced by dyspnœa and stridulous respiration, the characteristic symptoms of that condition. Titillation and cough are not so frequent as in inflammations of other origin. In many instances there is no tickling, cough, pain, or dysphagia. Dysphagia is not present unless there is œdema of the parts employed or pressed upon in deglutition.

In tertiary syphilis of the larynx the symptoms are usually those of impairment of phonation, followed in severe cases by dyspnœa and stridor also, chiefly inspiratory. The stridor is worse at night, from inaction of the auxiliary muscles of respiration. Should the mechanical impediment to respiration increase, inspiratory depression of the soft parts below the sternum takes place. If relief is not obtained, artificially or otherwise, asphyxia supervenes from imperfect aëration of the blood. Suffocation may occur suddenly from impaction of detached cartilage, but is more frequently slow enough in its approaches to allow time for tracheotomy. Titillation and cough are more frequent in the earlier stages than in secondary syphilis, but they diminish after ulceration has taken place, except in so far as they are produced from time to time by morbid products detained upon diseased and adjacent surfaces. Pain is infrequent before the period of ulceration; after that it may be severe, and radiate into the ears as in other ulcerative diseases. In the early stage there is no expectoration. The earliest expectoration is of collateral catarrhal products only. As ulceration progresses it becomes muco-purulent, and then purulent and sanguineo-purulent, and mixed with detritus according to the stage and location of the lesion. If gangrene takes place the odour becomes fœtid, and the expectoration contains fragments of dead soft and cartilaginous tissue, as may be. Dysphagia ensues when the disease is in a locality to interfere with deglutition, and odynphagia when ulcerations have occurred in the same localities.

In tertiary syphilis of the trachea the symptoms affect mainly the function of respiration, the voice often remaining normal even when

[1] A Paper read before the Philadelphia County Medical Society, September 12, 1888.

breathing is seriously embarrassed. Pain along the course of the trachea, if constant, is indicative of lesion at that particular point. Cases may run their entire course without any special symptom, even in the presence of stricture of the trachea and of the bronchi and of extensive disorganization as revealed at the post-mortem examination.

In hereditary syphilis the symptoms are sometimes congenital and may remain practically continuous for years. Respiration and phonation are both affected. The cry of the infant sometimes possesses a shrill metallic resonance which has been compared to that of a tin trumpet. Cough is more frequent in the child than in the adult. Deglutition is often difficult and sometimes painful. Expectoration occurs in the suppurative stages when the child is old enough to expel the products, which by infants are swallowed or retained in the air-passages. Laryngismus is a symptom of frequent occurrence in young children.

Etiology.—The probable condition attracting the manifestation of constitutional syphilis to the larynx is superficial catarrhal laryngitis from hereditary or acquired proclivity, or from exposure, or from abuse of tobacco or alcohol or other indulgence, or from misuse of the voice. Such exposures cause more males to be affected than females, as there is no assignable sexual reason for preponderance. Tracheal lesions, on the other hand, have been reported more frequently in females, probably because the laryngeal lesion is attended to more promptly by the male. Syphilitic disease often extends by continuity from the oropharyngeal region to the larynx, principally along the pharyngo-epiglottic fold to the epiglottis, and thence along the arytæno-epiglottic fold, and from the two structures to the interior. Hereditary syphilis has been observed in intra-uterine life (Monti, *Medical Times*, Philadelphia, April 28, 1877, p. 336). Hereditary syphilis of the most intense character has been occasionally observed at a very early age, as in the case of an infant whose symptoms began with coryza in the tenth week of life, and terminated in death by suffocation from stenosis nineteen days later. Post-mortem, the examination revealed, in addition to syphilitic lesions in the liver, destructive perichondritis of the cricoid and left arytænoid cartilages, and fatty degenerations of the arytænoid and both posterior crico-arytænoid muscles and the left superior nerve (Fränkel, "Wien. med. Woch.," 1868, Nos. 69, 70, cited by von Ziemssen and by Mackenzie). Children less than a year old often show laryngeal lesions of hereditary syphilis, and ulcerative lesions have been seen at two months of age (Parrot, "Prog. méd.," 1878, p. 635). Many cases occur in children but a few years of age, and sometimes the manifestations are deferred to the period of puberty or even later. Indeed, in opposition to the received opinion of syphilographers, I have reason to believe that in a few instances I have seen its manifestations delayed as late as the third and even the fourth decennium. True, in such instances as the latter it is quite possible that infection may have been acquired in some method unknown, without having been followed by any secondary manifestations, or that early hereditary manifestations may have escaped recognition. The secondary manifestations occur most frequently in adolescents and young adults. They appear most frequently at periods

varying from a few weeks to a few months after infection, sometimes as late as the fourteenth or seventeenth month (Morgan). Tertiary lesions are most frequent at rather maturer ages, and occur occasionally in quite advanced life. They have been reported as early as the sixteenth month (Türck), and as late in their first appearance as the thirtieth (Türck), and even the fiftieth year (Mackenzie). Tracheo-bronchial tertiary lesions have been reported as appearing as early as the ninth month after infection, but these lesions are usually coincident with the laryngeal lesions when not immediately consecutive to them. Most of the instances of tracheal syphilis occur in individuals whose employments expose them to irritation from dusts of various kinds (Vierling, "Deutsches Arch. f. klin. Med.," 1878, Bd. 21). Hereditary tracheo-bronchial syphilis is far less frequent than the laryngeal forms. It has been observed before the age of puberty.

Diagnosis.—The differential diagnosis between secondary and tertiary lesion is sometimes difficult, particularly in the transitionary period especially described by Whistler. The discriminating characteristics are less well marked in the laryngeal syphilis, perhaps, than in any other variety. It may, however, be broadly stated that secondary lesions, erythematous, papular, condylomatous, or paralytic, are superficial; and that tertiary lesions are gummatous, ulcerous, carious, necrotic, and deep-seated. Laryngitis occurring within a few months of infection is almost invariably secondary. Lesions appearing before the termination of the third year are presumptive secondary; those appearing within the third year, secondary, or transitional; and those appearing after the termination of the third year, tertiary. Nevertheless, secondary lesions may be ulcerous, and undoubted tertiary manifestations have been recognized even within nine months of infection.

The history of the case, and the previous or actual presence of manifestations of syphilis elsewhere, are the main positive factors in the diagnosis of specificity, especially in the early stages of either variety. The later lesions of tertiary syphilis are often sufficiently characteristic; sometimes not at all so. In cases of doubt, anti-syphilitic treatment will almost always detect a lesion of syphilitic origin, but not invariably. Hence, in instances of strong suspicion, the various methods of anti-syphilitic medication should be thoroughly tried before that test is abandoned. This suspicion is justifiable in cases of obstinate chronic laryngitis, whether ulcerative or not, in individuals in whom no other appreciable local or constitutional cause can be detected.

Laryngoscopic inspection is an invaluable aid in diagnosis; though practically indispensable, it is inadequate for fully appreciating the extent of deeply-seated lesions; and its revelations are not always sufficient to establish the diagnosis in the absence of corroborative lesions elsewhere. The erythematous and catarrhal inflammations of secondary syphilis, when diffuse, are not to the ordinary eye distinguishable from similar non-specific conditions. Circumscribed erythema, though usual in syphilis, occurs in non-specific laryngitis also, consequently that condition alone is insufficient for discrimination. Patchy erythema on the vocal bands and elsewhere may be regarded as characteristic. Not

so, however, the shaded pigmentations, at the extremities of the vocal bands.

Symmetric bilateral localization of erythematous and other patches is highly characteristic of secondary syphilis ; but a contrary condition by no means excludes the diagnosis. Isolated bilateral congestions of the supra-arytænoid structures and of the Wrisbergii have been cited as pathognomonic. Nothing can be more fallacious or misleading. Enlarged inguinal and post-cervical glands furnish excellent corroborative testimony of syphilis. Papules or condylomata upon an erythematous mucous membrane are to be considered pathognomonic. Their recognition may require an exceptionally good light on the one hand, or repeated examinations on the other. They must be carefully discriminated from minute collections of mucus or saliva. Diffuse gummatous infiltration is to be distinguished first from inflammatory syphilitic infiltration by the co-existence of gummatous processes elsewhere, its more circumscribed contour, and its sharper definition. The differential diagnosis is much easier after it has reached the stages of liquefaction and ulceration.

Syphilitic ulceration usually proceeds from above downward, rarely in the opposite direction, and often in extension from ulceration in the pharynx. Repair usually proceeds from below upward. Apart from these guides there is nothing positively characteristic enough to determine an ulceration to be syphilitic in character by mere inspection. The absence of pain has been regarded as characteristic ; but, on the one hand, carcinomatous ulceration often exists without pain, and, on the other hand, the ulcerative lesions of syphilis are sometimes attended with lancinating pains of the most severe character.

In the gummatous stage of tertiary syphilis the diagnosis is not difficult. Nodular syphilides and gummata are recognized in the forms and at the localities mentioned under pathology. They may be confounded with other neoplasms, and with abscess. In cases of doubt, antisyphilitic treatment should clear up the diagnosis. The physical distinction between gummata and condylomata may in some instances be obscure (Semon). The main reason why gummata are so infrequently seen as to have led some observers to an erroneous opinion as to their rarity, is that many patients do not present themselves until after the stages of liquefaction and ulceration have become established. When this stage has not been observed, and the larynx, as is more usual, is not inspected until after ulceration has considerably progressed, the appearances are not always characteristic. They may be confounded with those of lupus, carcinoma, and tuberculosis. The general diathesis, the clinical history, the existence of enlarged submaxillary and post-cervical and lymphatic glands, the character of concomitant affections of the skin and mucous membrane, the aspect of the patient, assist in discrimination. Sometimes, too, tuberculous and syphilitic lesions co-exist.

The typical tertiary ulcer, sharply defined, and below the surface of the mucous membrane, is more or less circular when recent, more or less crenated when reparation is taking place at one or more points of the circumference, and looking as though cut out with a punch when in œdematous tissues. Its borders are sharp, elevated, but not often

undermined, and more or less rounded in their visible outline, and are surrounded by a more or less circumscribed inflammatory areola in the mucous membrane. The bottom feels hard to the probe on palpation. The bed of the ulcer is grayish or lardaceous, yellow from fatty detritus, and covered with adherent concrete pus, through which, here and there, prominent rosy granulations often project. The surrounding tumefaction is harder and more indurated than in other varieties of ulcer. Purulent accumulations are rather indicative of the syphilitic process. At a later date denuded or necrosed cartilage may be visible in suitably located ulcers.

In cases in which neoplasms have become developed at the seat of existing ulcerations, or of cicatrized ulcerations or erosions, it is often impossible to pronounce as to their nature, even by the test of anti-syphilitic treatment. Not only do such neoplasms exist independently of the syphilitic process, or as the result of irritation provoked by a syphilitic process in the vicinity, but, when undoubtedly syphilitic in origin, they rarely disappear under specific medication. Tertiary syphilis is usually recognizable in the stages of œdema of the larynx ; and almost always in the reparative stages of cicatrization, or in the subsequent stages of stenosis, whether from cicatricial retraction or from organization of effused products.

Prognosis.—Secondary lesions, even when ulcerative, are most frequently curable without cicatrix or without any other sequel. Exulceration of the vocal bands sometimes leaves permanent defect of tissue. The prognosis is good except during temporary conditions of œdema, when it may be grave for the time being. The inflammatory congestion and turgescence are more chronic than in catarrhal inflammations, and are often recurrent. Actual hyperplasia is apt to remain permanent, even after cure of the syphilitic lesion, despite the most assiduous treatment ; and when it occupies the vocal band the voice may be permanently impaired. The singing voice may remain imperfect, although the conversational voice is fully restored, the injured tissues being unequal to the nicety of adjustment requisite for cantation.

In tertiary lesions the prognosis depends mainly on two factors : First, on the impairment of the general health, and the significance of lesions elsewhere, especially in the brain and meninges, and in other important organs. Second, in the extent of ulceration and the character of deformation or stricture which may follow. Temporary gravity exists in the presence of œdema, during the period of exfoliation of necrosed cartilages, and in acute bilateral paralysis of the dilator muscle, the result of exposure to cold or other cause, or to unilateral paralyses when the opposite side is immobile from gumma, or from crico-arytænoid ankylosis (Charazac, "Rev. mens. de lar.," September, 1884), any of which conditions may demand prompt tracheotomy to prevent death by suffocation. Ulcerative lesions of the trachea may be fatal by hæmorrhage from penetration of large blood-vessels ; by pneumonia from access of food through perforation of œsophagus (Berger) ; or by septic processes due to rupture of the mediastinum. Permanent impairment of the voice is to be expected in all cases in which the vocal bands undergo serious injury, and in many in

which permanent changes are likely to take place in other structures contiguous to the glottis. Deglutition is rarely affected, even after complete destruction of the epiglottis ; and in exceptional cases difficulty is mainly confined to fluids swallowed without deliberation. Stricture rapidly supervening upon hyperplasias is often amendable to active treatment, sometimes with striking rapidity (Krishaber) ; but the more frequent stricture of slow progression can only exceptionally be brought under control. Serious danger attends even cure of extensive ulcerative lesions in the interior of the larynx, for the resulting stricture, if severe, is likely to necessitate tracheotomy, with great probability of permanent retention of a cannula. It is rarely amenable even to excision of cicatrical tissue by external access. Subglottic stricture is much more serious than supraglottic, and tracheal far more serious than laryngeal stricture. Stricture of the trachea, when low down, is practically insusceptible of amelioration, and death by slow apnœa, or by sudden suffocation, is the usual outcome.

When the syphilitic cachexia has advanced so far as to have produced incurable lesions in important viscera or in the cerebrum, death may ensue from these causes despite sustained cure of syphilitic lesions in the larynx. In cases complicated with paralysis of the dilator muscles of the larynx from cerebral lesion, death may take place by occlusion of the glottis and suffocation, or by encephalitis and coma.

In hereditary syphilis the prognosis is very much the same as in tertiary syphilis, being much worse in infancy and childhood than in more delayed manifestations. The small size of the larynx renders stricture and intercurrent œdema far more significant ; and the tendency to spasm of the larynx inherent to all laryngeal affections in childhood presents an additional element of danger. Fatal issues from these three causes are not infrequent. An element of uncertainty as to the final result remains in all varieties of syphilis of the larynx and trachea, due to the fact that permanent liability to recurrence prevails in many instances, despite the best apparent results of the most judicious treatment ; and often, too, after prolonged intervals of immunity from any further manifestation of constitutional syphilis.

Treatment. — Fortunately, lesions even of great destructive and menacing tendency are amenable, as a rule, to treatment ; often promptly. The treatment, broadly stated, is that applicable to constitutional syphilis in general ; mercury in the early manifestations and iodides in the late ones. In many of the latter, if not most, the "mixed treatment," combining the two specifics, is the most serviceable. In congenital syphilis the gray powder is believed to be the most efficacious form of the drug. While willing to admit that secondary lesions often subside without traces and without much risk of subsequent tertiary manifestations, although mercury is withheld, I deem it the more prudent practice, and therefore the best practice, to employ mercury, in the belief that its specific constitutional influence affords the patient better protection as to future manifestations. As to the value of iodides in tertiary syphilis, there is no difference of opinion. Tonics are often indicated. All sources of irritation, exposures, excessive use of the

voice, alcohol, and tobacco, are to be avoided. Sedative inhalations in vapour or spray are often of great topical benefit in subduing collateral inflammation; and antiseptic inhalations are indicated in gangrenous cases.

Secondary syphilis. Mercury may be administered by the stomach or by the skin. When the lesions are moderately severe or slow in progress, the corrosive chloride may be administered, in doses of from one sixteenth to one eighth of a grain, three times a day. The green iodide may be given in doses gradually increased from one sixth of a grain three times daily to the point of tolerance. The addition of extract of belladonna may cause it to be better borne by the stomach. In individuals in whom serious gastric disturbance is produced before any specific effect has been noted, and in seriously severe cases and cases of rapid progress, inunctions of a drachm of mercurial ointment daily are preferable, or pencillings with solutions of oleate of mercury in oleic acid, ten per cent. Lewin prefers hypodermatic injections of corrosive chloride. Concurrent stomatitis is to be combated by the internal administration of potassium chloride, or the use of a saturated solution of that salt, or of a weak solution of potassium permanganate as a mouth-wash. It is hardly necessary at the present day to mention that salivation is to be avoided. In his own experience topical medication is, as a rule, superfluous in non-ulcerative secondary syphilis, and often unnecessary in the presence of ulceration. When topical medication seems necessary, inhalations of sprays of corrosive chloride (Demarquay), half an ounce or more daily of a solution containing one grain to four ounces of water, are useful locally and constitutionally. In particularly obstinate conditions, especially in the presence of hyperplasias, the topical application of solutions of iodine and potassium iodide in glycerin (Schnitzler), half a drachm and a drachm respectively, to the ounce, made daily or at longer intervals, sometimes accelerates the cure.

In the transitional stage and in the tertiary stages the "mixed treatment" has been the most beneficial in his own practice; one-sixteenth to one-eighth of a grain of the corrosive chloride, five to ten grains of potassium iodide in half an ounce or more of the compound syrup of sarsaparilla, three times a day. It may sometimes be necessary to increase the dose of iodide up to the point of tolerance. In such cases the "grain-to-drop" solution is the most convenient preparation. The danger of inducing œdema of the larynx by sudden large doses must not be forgotten. When necessary, sodium or ammonium iodide may be substituted for the potassium salt, or hydriodic acid may be employed.

In the presence of œdema, hypodermic injections of corrosive chloride (Lewin), one-thirtieth of a grain, twice a day for a day or two, and, after improvement, at intervals of three days or more, have proved quite efficacious. If amelioration is not prompt, and if the patient cannot be carefully watched by an attendant competent to interfere in an emergency, it is best, in the author's opinion, to perform prophylactic tracheotomy, instead of awaiting its urgent indication. The same rule is applicable to threatening cases of extensive hyperplasia, whether from specific or from non-

specific infiltrations. Nevertheless, remarkably happy results, even in urgent cases of these kinds, have frequently followed active treatment by inunction (Krishaber) and by hypodermatic injection (Lewin). Intubation of the larynx from the mouth (O'Dwyer) has been recommended as applicable in many instances of œdema and constriction heretofore treated by tracheotomy. As yet, the author knows of no experience with intubation in this special connection.

Ulcerations heal more promptly when the constitutional treatment is seconded by topical cauterizations with fused silver nitrate, or with mercuric nitrate, one part to from four to ten parts of water, or with cupric sulphate in crystal or saturated solution. Chromic acid, one part in from five to eight parts of water, has long been extolled (Isambert). Some prefer iodoform (Morgan). On the other hand, extensive ulceration often heals promptly under the influence of constitutional treatment alone.

Vegetations, detached flaps of mucous membrane, and semi-detached fragments of necrosed cartilage call for operative removal with cutting forceps, evulsion forceps, or snares, as may be most convenient, when these products are so located as to interfere with freedom of respiration or to threaten such interference. When these manipulations are impracticable, tracheotomy may be requisite. When tracheotomy has been performed under any of the conditions mentioned, the cannula is to be removed as soon as it has become apparent that its retention is no longer essential to the safety of the patient. Cicatricial stricture of the larynx may be treated by the introduction of the intubation-tube through the natural passages (O'Dwyer). This treatment may be applicable to stricture high up in the trachea. Stricture in the middle portion of the trachea requires low tracheotomy and the introduction of a tube long enough to reach beyond the constriction. Stricture at the bifurcation is hopeless.

Paralyses, even those of the posterior crico-arytænoids, are usually amenable to antisyphilitic treatment even when of considerable standing. This fact seems to indicate that the atrophy found in necrotic paralysis is not due to simple inaction of the muscle, but rather to trophic impairments of neurotic origin. Electrisation may be employed when relief does not ensue from systemic medication.

Membranous webs, occluding the glottis from side to side, are divided by incision or by the galvano-cautery, the edges cauterized, and re-adherence prevented, if possible, by frequent introduction of dilating sounds. These laryngoscopic operations are often rendered futile by an insurmountable tendency to recicatrization, whereby the morbid condition is reproduced. Success in cases of this kind would seem to require exposure of the interior of the larynx by external division of the thyroid cartilage, and excision of the whole of the cicatricial tissue (Mackenzie).[1]

When syphilitic laryngitis has existed for a long time, such an amount of destruction may have taken place, and such a degree of systemic poisoning, as to render recovery impossible. The constrictions produced by the cicatrices of extensive ulcers, and the adhesions between adjoining

[1] *Med. Times and Gaz.*, August 19, 1871, p. 218.

surfaces, in patients who recover, are often such as to render tracheotomy necessary, with the permanent use of the tube ; for the constrictions following syphilis are not, as a rule, amenable to dilatation.

Threatened asphyxia or unconquerable dyspnœa, from gumma, loose cartilage, morbid growth, abscess, or œdema, may necessitate tracheotomy. Tracheotomy for the purpose of conquering dyspnœa due to tumefactions in the larynx is perfectly justifiable and usually successful. It is likewise justifiable for the mere purpose of securing rest to the organ—much more so, indeed, than in analogous conditions attending tuberculosis.

The treatment for local adhesions consists in relieving the tension as far as possible by laryngoscopic division of the constricting bands of tissue, with the knife or with the electric cautery, and then cauterizing and recauterizing the adjacent surfaces, to prevent fresh adhesions. These cases require careful watching and prompt attention to overcome the disposition to recurrence, which is very apt to take place in spite of all efforts. When the epiglottis is implicated, much good can be done by teaching the patient to move the organ frequently by means of his forefinger.

In a case of stenosis due to "concentric hyperchondrosis," as a result of the hyperplastic chondro-perichondritis, Heine has performed a successful resection of the anterior portion of the thyroid cartilage, splitting that structure in the middle line, separating the perichondrium and superjacent soft tissues, to the distance of one half its surface on the two sides, with the elevator, and then removing the denuded portions by longitudinal section with a bone forceps. The patient rallied so well from the operation that an artificial vocal apparatus could be substituted for the ordinary cannula on the fifth day. He became able to resume work after a while ; but the disease made new inroads, and he died, eleven months later, in an advanced stage of tuberculosis.

Despite the most judicious treatment, and the most satisfactory immediate results, recurrence or recrudescence takes place in many instances at variable intervals, requiring the resumption of specific treatment. The most satisfactory results alleged by any writer have been in cases actively treated by Lewin with hypodermatic injections. It is advisable to keep patients under observation for many months after active treatment has been discontinued. Mercuric iodide (biniodide) in small doses, one twentieth to one tenth of a grain, three times daily, may judiciously be prolonged for long periods during which apparent health exists. Potassium iodide, in diminishing doses, should be administered from time to time for a few days every month until the patient begins to show susceptibility to physiological effects from small doses ; and then this susceptibility should be tested from time to time at intervals of a few months. Such supervision for two years at least seems to present the best prospect for riddance from the diathesis. It may be mentioned in conclusion that, under intercurrent attacks of erysipelas, obstinate cases of tertiary syphilis of the larynx and trachea have undergone cure after having resisted all medicinal treatment.

THERAPEUTICS AND DIPHTHERIA.

LICHTWITZ.—On Creolin, and its Employment in Diseases of the Throat and Nose. *Bulletin Medical, September* 30, 1888.

In two cases of bad ozæna, treated with nasal douches of weak emulsions of this substance and performed twice a day, the author has met with very good results, the bad odour having completely disappeared. This disinfectant power has also been used in a case of epithelioma of the right maxilla, which had given rise to empyema of the antrum of Highmore, a few injections having completely removed all bad odour. After operations upon the nasal fossæ, the author employs creolin tampons and gauze. Gargles of creolin give good results in follicular tonsillitis and after operations on the throat. **Joal.**

BEEHAG, ALBERT J.—(Edinburgh).—Menthol in Diseases of the Throat and Nose. *Edin. Med. Journal, January*, 1888.

The writer seeks to extend Rosenberg's menthol treatment of pulmonary and laryngeal phthisis to other affections, such as acute and chronic nasal catarrh, ozæna, the rhinitis of scrofulous children, acute catarrhal angina, and chronic pharyngitis with hyperæsthesia or paræsthesia. He recommends that it should be applied in oily solutions, powders mixed with ammonium chloride and boric acid, or added to Mandl's formula.

[We have in several cases of laryngeal phthisis found the pain relieved by the insufflation of menthol, and the patient's condition improved, but we do not agree with the recommendation to use the powder in chronic dry nasal catarrh, as we have seen cases rendered very much worse by its application.] **Maxwell Ross.**

COUPARD.—Gelosine in Stricture of the Nose and Larynx. *Rev. Mensuelle de Laryng., September*, 1888.

The malleability of gelosine permits of its being moulded into any form and shape, and it can further be mixed with various medicaments, such as iodoform, cocaine, boric acid, etc., thus making its use most valuable. Under the influence of moisture it triples in volume, and it is not modified by iodoform and ether. **Joal.**

GUINIER. — On the Employment of Sulphur in Laryngeal Phthisis. *Rev. Mensuelle de Laryng., September*, 1888.

An answer to the adverse criticisms of Moure and Charazac, who have condemned the use of sulphur in these conditions. Guinier maintains that the waters of Cauteret possess a sedative, antispasmodic, and antiphlogistic action, and have an elective power upon the tissues and innervation of the respiratory organs. **Joal.**

DE CRESANTIGNES.—Contribution to the Etiology of Diphtheria. *Société de Médecine Pratique, July* 5, 1888.

THE relation of twelve well observed cases in which the transmission of diphtheria appears to have been conducted to a distance by the intermediation of an individual who was not affected with the disease, but who had dwelt a more or less long time in the atmosphere of contaminated subjects. The author considers that this mode of contagion is far from exceptional. **Joal.**

LA PEYRE.—Epidemic of Diphtheria, *Journal de Médecine, August* 15, 1888.

DETAILS of an epidemic occurring in the country and in which out of 32 cases there have been eight deaths, that is a mortality of 25 per cent. A very significant total. The author has used quinine internally and tincture of iodine locally. He has not performed tracheotomy. **Joal.**

GUELPA.—Treatment of Diphtheria. *Bulletin Thérapeutique, September* 15, 1888.

EVERY diphtheritic angina uncomplicated with any other infectious affection is followed almost without exception by cure in the space of a week, if it is combated from the first twenty-four hours of its existence with abundant irrigations of perchlorated water applied to the throat and nose, if these irrigations are practised at least two or three times hourly day and night. This treatment prevents the extension of the disease to the larynx and trachea in cases of croup, especially if tracheotomy is practised early we have in spraying through the cannula the means of checking the disease and giving increased chances of cure.

Joal.

BLEYNIE.—The Treatment of Diphtheritic Sore Throat and Croup. *Journal de Limoges, March*, 1888.

IN the author's opinion the appearance of a diphtheritic membrane is the initial symptom of the disorder, and it precedes general infection. It is necessary to treat it locally in the following manner. A small piece of ice is introduced into the mouth every ten minutes, day and night, even during sleep. From the second to the tenth day give ice every half hour, every hour, then every two hours. The throat should be treated with iced water every five minutes. **Joal.**

HUGUENIN.—Contribution to the Study of Diphtheritic Myocarditis. *Rev. de Méd., October*, 1888.

THE author relates a case of myocarditis occurring in the course of diphtheria and terminating in death. The observation is accompanied with a description of the histological examination of the anatomical parts.

Joal.

MOUTH, TONSILS, PHARYNX, &c.

NETTER.—The Presence of the Streptococcus Pyogenes in the Saliva of Healthy Subjects. *Société de Biologie, July* 21, 1888.

THE author has been able to demonstrate the existence of this organism in the saliva of seven healthy subjects presenting no suppurative or other lesion of the air or digestive tracts. From this circumstance the penetration of the tonsils by the streptococcus is to be explained, the organism often passing into the blood and engendering those kinds of infectious tonsillitis which are so often followed by septicæmia or purulent infection. **Joal.**

VALUDE.—Tuberculosis of the Salivary Glands. *Congrès Tuberculose, Paris, July,* 1888.

TUBERCULAR degeneration of the salivary glands is almost unknown. The author asks, Why should tuberculosis prove so difficult of implantation upon the surface of the mouth or in the salivary glands? What is the obstacle which opposes the development of tuberculosis in the mouth? From the experiments of the author he draws the conclusion that this obstacle is due to the accumulation of micro-organisms of every kind, able by their power of reproduction to oppose the germination of the microbe of tuberculosis. **Joal.**

LANG, Dr. SCOTT (Edinburgh).**—Salivary Fistula.** *Edin. Med. Journ., June,* 1888.

A PATIENT shown to the Medico-Chirurgical Society suffering from this condition. The external opening was about half-an-inch behind the lobule of the right ear. **Maxwell Ross.**

TRENGRUEBER.—The Treatment of Cancer of the Mouth. *Acad. de Méd., September* 11, 1888.

THE author presented a patient upon whom he had operated on March 2nd, removing the greater part of the tongue, the floor of the mouth, and a large part of the superior maxilla. On April 4th the patient left St. Louis Hospital, and his general condition is now very satisfactory. **Joal.**

RECLUS.—Leucoplasia and Cancroid of the Buccal Mucous Membrane. *Gazette des Hôp., June* 28, 1888.

THE author cites many cases of buccal psoriasis in which he has been able to follow the complete evolution of the leucoplasia from the opaline "tache" through the yellowish thickened "plaque," through cancroid to epithelioma, which is its termination. The author does not think that cancroid is the direct consequence of psoriasis. The examination of the texture of the plaque furnishes no information, the two lesions are absolutely independent of each other. One may agree with Besnier and Trélat that the psoriasis plaques are incessant causes of irritation, and further, that every irritation, as one knows, favours the development of cancroid. **Joal.**

CAZENAVE DE LA ROCHE. — **Glossodynia treated by Igni-puncture.** *Révue Thérapeutique et Clinique, June* 21, 1888.

THE case of a patient, fifty-eight years old, affected with glossodynia, which was especially located on the right base of the tongue, the pains radiating into the throat and the ear. Six cauterizations with the thermo-cautery cured the condition, which appears to us to have been simply a lingual amygdalitis. **Joal.**

KIRMISSON.—**The Surgical Treatment of Cancer of the Tongue.** *Bullétin Med., September* 12, 1888.

A LECTURE given at the Necker Hospital *àpropos* of a case of epithelioma of the tongue, in which the author insists upon the employment of rigorous buccal antisepsis before operation. **Joal.**

SEIFFERT (Würtzburg).—**A Rare Cause of Reflex Neurosis.** *Sitzungsberichte der physikal-med. Gesellch. zu Wurtzburg*, 1886.

ASTHMA and abnormal sensations in the throat were caused by a papilloma situated on the base of the tongue. After removal of the neoplasm the symptoms were cured. **Michael.**

OUSPENSKI.—**Tonsillar Hypertrophy in Infancy: its Importance and Treatment.** *Annales de l'Oreille, &c., July*, 1888.

THE author has observed fifty-two cases, and he has found among more than half the number a diminution in size, in weight, and in volume of the chest, in three quarters of the children, enfeeblement of hearing; and in a third, myopia, and deficiency of intellectual development in most. Ouspenski is an advocate for the use of the galvano-cautery in removing hypertrophies of the tonsils. **Joal.**

BALME.—**On Hypertrophy of the Tonsils.** *Thèse, Paris*, 1888.

THIS is an excellent work founded on material at the Clinque des Sourds Muets, and made under the direction of Dr. Ruault. The author commences with the anatomical study of the structure of the pharyngeal, palatine, and lingual tonsils, then he passes in review the different physiological rôles attributed to the tonsil, and occupies himself with the relations of the tonsil and genital organs, speaking also of tonsillar reflexes. After an important chapter devoted to the pathological anatomy of the affection, Balme discusses the symptomatology, and after having indicated for each region (palatine, pharyngeal or lingual) the signs furnished to vision and touch, he studies carefully the functional troubles digestive, respiratory, vocal, auditory, &c., resulting from tonsillar hypertrophy. The different treatments employed are discussed, and curative methods are reviewed. Lastly, the numerous original observations collected by the author support the ideas emitted in this excellent work.

Joal.

GALLIARD.—**On Hypertrophy of the Tonsils.** *Soc. de Méd. Pratique, July*, 1888.

THIS is an excellent monograph on the subject in which the author makes

a complete study of the etiology, symptomatology, diagnosis, treatment, and especially of the pathological anatomy of the condition. He has drawn benefit from the work of Cadier. Joal.

WERNER (Markgronnigen).—**Excessive Hæmorrhage following upon Galvano-Cautery Treatment of an Hypertrophied Tonsil.** *Würtemburg Med. Correspondants Blat.*, No. 31, 1888.

SUCH hæmorrhage occurred five days after the galvano-caustic treatment of an hypertrophied tonsil, that the patient became very anæmic, and was reduced to a condition of extreme danger. The patient was only saved by making compression of the carotid for ten days. The case also shows that gavano-cautery treatment is not free from complications. Michael.

DUCHESNE.—Spasm of the Pharynx, accompanied with Abundant Expectoration, in a Child four years old. *Société de Médecine Pratique, June* 11, 1888.

THE relation of the case of a child four years old, who, on being put to bed each night, is attacked with a sort of nervous crisis, with violent contraction of the pharynx and very abundant expectoration. The author cannot explain this phenomenon. The examination of the pharynx and naso-pharynx has not, however, been made. Joal.

SPRENGEL (Dresden).—**Operations for Retro-Pharyngeal Abscess** *Jahrsberichte der Gesellch. für Natur und Heilk. in Dresden*, 1887, 1888.

THIS is a recommendation of the operative method advocated by Burkhardt, namely, opening through the neck and not through the mouth. Three cases so treated and cured are related by the author. Michael.

TSCHARMER (Graz).—**Dysphagias Caused by Diseases of the Bronchial Glands.** *Jahrbuch für Kinderheilkunde*, Band 28, Heft 3.

AFTER having referred to three cases which he has found in literature, the author describes one occurring in his own practice as follows: A cachectic child one year old could not swallow fluid food. A bougie, however, could be easily introduced into the stomach so that cicatricial stenosis could be excluded. The condition lasted for three years. The child had also all the symptoms of tuberculosis and ultimately died from this. An autopsy could not be made. Michael.

SUAREZ DE MENDOZA.—Foreign Body in the Œsophagus. *Acad. de Med., September* 4, 1888.

A CASE in which a foreign body was lodged in the œsophagus, twenty-three centimetres behind the teeth, and was removed upon the fifth day by Colin-Verneuil's œsophageal sound. Joal.

SCHWARTZ.—The Treatment of Strictures of the Œsophagus. *Sémaine Médicale, August*, 1888.

APROPOS of the case of a patient having cicatricial stricture resulting from poisoning by phosphorus, and who had gastrotomy performed,

Schwartz delivered a lecture at the Hospital Beoujon upon the treatment of this condition, and upon the operation of gastrotomy.

Joal.

KIRMISSON. — Permanent Catheterism in Cancer of the Œsophagus. *Acad. de Médecine, July* 2, 1888.

MANY facts observed by the author prove that the prolonged employment of the permanent sound has never produced any appreciable lesion in the œsophagus. The result obtained is not inferior to that given by gastrotomy, and the terrible mortality of this operation is avoided. Kirmisson employs Krishaber's sound, which he prefers to Symonds's tubes.

Joal.

RUPPRUCHT (Dresden).—**A Case of Œsophagotomy.** *Jahresberichte der Gesellch. fur Natur. und Heilk. in Dresden,* 1887, 1888.

THIS was a case in which œsophagotomy was performed for the extraction of artificial teeth. The patient was afterwards treated by permanent catheterization and cured. The author concludes with the following remarks:—1. The impossibility of swallowing compact food is characteristic of the presence of foreign bodies. 2. Diagnosis should be made by hard and not by soft bougies. 3. Impaction of sharp foreign bodies is an indication for the performance of œsophagotomy as early as possible, since the danger of hæmorrhage is great.

Michael.

NICAISE.—Gastrotomy in Cancer of the Œsophagus. *Acad. de Méd., July* 10, 1888.

THE case of a man, seventy-five years old, having cancer of the œsophagus. Alimentation had become impossible, and death being only a question of rapid onset, the operation was proposed and performed on March 22nd. The result was good, and on the seventh day strength had already returned and the sensation of hunger had re-appeared. In July, however, the appetite diminished, the patient became enfeebled and succumbed on September 1st, five months and ten days after the operation. Nicaise is of opinion that the fear with which gastrotomy is regarded is not well grounded. If recourse is had to the operation early, one can see from statistics that it prolongs life to a greater degree than the employment of the œsophageal sound. It is, however, necessary to practice it as soon as there is a mechanical hindrance to the ingestion of food.

Joal.

NOSE AND NASO-PHARYNX.

ANNANDALE, PROF. (Edinburgh).—**Appliances for Support of Nasal Bones or Septum after Operation or Fracture.** *Edin. Med. Journ., April*, 1888.

SHOWN at a meeting of the Medico-Chirurgical Society. It consists of an arch of sheet-lead, which is fixed over the nose and transfixed along with the tissues by a needle, the whole being fixed by a loop of silver wire secured over the arch. The advantage of the lead is that it can be moulded to the nose so as to exercise a proper lateral pressure, and so shape the organ. Maxwell Ross.

SCHMIEGELOW, E.—Purulent Discharge the Nose. From its Significance and Treatment. With Report of Twenty-three Cases of Empyema of the Antrum of Highmore, of the Ethmoidal Cells, and of the Frontal Sinus. *Hospitals Tidende, February*, 1888.

THE article, which is written for non-specialists, contains reports of cases of empyema of the above-named cavities.

The author performed operations through the alveolar process in fifteen cases of empyema of the antrum of Highmore, while in one case it was sufficient to extract a tooth, and four of the patients did not submit to any operation. In one case where the symptoms of empyema had lasted twelve years, sarcoma developed.

The author attributes the cause of the empyema in thirteen cases to dental diseases, and in six to the extension of purulent nasal catarrh to the antrum, while only in one case could no cause be detected. Twice the primary purulent nasal catarrh was caused by nasal operations.

One case of empyema of the frontal sinus was cured by external operation, while in another case cure was established only by removing with the snare polypoid swellings of the concha media, and by application of chromic acid to these. One case of empyema of the ethmoidal cells was cured by application of chromic acid to the anterior part of the concha media. Holger Mygind.

LACOARRET.—The Treatment of Catarrh of the Nasal Fossæ. *Thèse*, Bordeaux, 1888.

THE author first studies the symptomatology of the different kinds of rhinitis (hypertrophic and atrophic). He passes under review the pathological theories of ozœna, then deals with the treatment of chronic catarrh, and insists upon the good effect of the waters of Salix de Bearn employed in the form of douches and local sprays. Joal.

DE CRESANTIGNES.—Epistaxis and Hysterical Mutism in a Man. *Journal de Médecine, August* 15, 1888.

THE case of an individual who became hypochondriacal after a traumatism of the head. He was taken one day with violent epistaxis, then

with mutism, and it was impossible for him to answer any questions although he understood what was said, but in spite of his efforts his lips remained immovable, and no kind of sound was produced. Some days after fresh epistaxis occurred, and notable amelioration of speech followed. Examination of the larynx and nose was not performed, and the diagnosis of hysterical mutism appears to us to be doubtful. **Joal.**

McBRIDE, P. (Edinburgh).—**Empyema of the Superior Maxilliary Antrum, with only Nasal Symptoms.** *Edin. Med. Journ., April,* 1888.

TWO cases occurring in the author's practice form the basis for an interesting discussion of the views of Fräenkel and Ziem. He draws attention to a marked redness of the gum corresponding to the affected antrum, which he believes has not been observed by previous writers.

Maxwell Ross.

McBRIDE, P. (Edinburgh).—**Methods of Treating Nasal and Naso-Pharyngeal Polypi.** *Edin. Med. Journ, August,* 1888.

A PAPER advocating the use of the cold snare in preference to the galvano-caustic loop. The galvano-cautery or chromic acid may be applied to the base or any polypoid tissue left behind. **Maxwell Ross.**

LE DENTU.—Elephantiasis of the Nose. *Soc. de Chirurgie, October* 24, 1888.

THE author presented to the Society a patient in whom he had operated by a simple abrasion without autoplasty. The result was excellent, and there was no hæmorrhage. **Joal.**

SYMINGTON (Edinburgh). — **Position of Eustachian Orifice,** *Edin. Med. Journ., May,* 1888.

A HORIZONTAL section of the skull showed that the edge of the vomer is not always a safe guide in the passage of the Eustachian catheter, as it was at least a quarter of an inch in front of the orifice. Dr. Symington had seen the same in other specimens. **Maxwell Ross.**

LARYNX.

EXNER (Vienna).—**Remarks on the Innervation of the Crico-Thyroid Muscle.** *Archiv. für Physiologie,* Bd. 43, Heft 1.

ACCORDING to this author this muscle is innervated by the superior laryngeal nerve as well as by the median laryngeal nerve. **Michael.**

JELENFFY (Buda Pesth).—**On the Anatomy, Physiology, and Pathology of the Muscles of the Larynx.** *Berlin klin. Woch.,* Nos. 35 and 36, 1888.

THIS is a paper treating of the question of paralysis or spasm of the

adductors and abductors of the larynx. We can only here give the conclusions arrived at, but the paper should be read in the original. 1. The antagonists of the cricothyroids are the crico-arytenoidei laterales, the crico-arytenoidei interni, and the crico-arytenoidei postici. 2. The transversus has no antagonist, and cannot, therefore, have antagonistic contractions. When it is contracted it must be taken as a symptom of irritation. **Michael.**

CHARCOT.—Tabetic Laryngeal Crises. *Journal Lucas-Championniere, October*, 1888.

THESE crises may be slight, and consist in attacks of cough resembling whooping cough with whistling, but with a deeper tone and accompanied with little roaring. In a second form there is a veritable apnœa with danger of death, epileptiform convulsions, and these phenomena may be reproduced seven or eight times a day. The third form is the gravest, and sudden death may occur. One ought, therefore, to perform tracheotomy. Tabes also gives origin to laryngeal accidents, which Charcot formerly described under the name of laryngeal vertigo. Belonging to a second category are those cases in which one finds a permanent condition of dyspnœa. The laryngoscope demonstrates a more or less complete paralysis of the posterior crico-arytenoid muscles.

Joal.

AUFRECHT (Magdeburg).—**Casuistic Communications.** *Archiv. für Klin. Med.* Bd. 43, Heft. 3.

1. PARALYSIS of the posterior crico-arytenoid muscles from cancerous degeneration of these muscles. A patient forty-one years of age had dyspnœa eight days. With the laryngoscope it was shown that the vocal cords were immobile in the phonatory position, and did not separate during inspiration. The patient died the same night suddenly from asphyxia before tracheotomy could be performed. The autopsy proved the larynx itself to be normal, but the crico-arytenoid muscles to be lost in a cancerous mass. 2. A case of cicatricial stenosis of the trachea. The patient, who had suffered for a year from hoarseness and dyspnœa died suddenly. At the autopsy it was found that the trachea was compressed by cicatrices and degenerated lymphatic glands. **Michael.**

FORT.—Ablation of the Larynx. *Bullétin Médical, July* 13, 1888.

ABLATION of a larynx affected with cancer may have fascinations for an operator who reduces surgery to a manual intervention. It cannot be accepted, however, by a surgeon who looks fairly at the indications, the dangers, and the ultimate results of the operation, and at the utility of such an operation for the patient. This article is an extract from a work in preparation entitled "Médecine operatoire." **Joal.**

SCHMID.—On Total Extirpation of the Larynx. *Greifswalder Medicinischer Verein, August* 4, 1888.

IN a patient referred to, the larynx was extirpated two years previously on account of a tumour. It could not be said certainly that this was carcinoma, because microscopical examination was not made, and the

cicatrix resembled luetic cicatrices. There was also an ulcer on the skin. The patient was quite cured, but the upper opening of the trachea is closed, and there is no communication between the trachea and mouth. This is also proved by laryngoscopical examination. For all this the patient has a loud voice, he can enunciate all letters, can speak during laughing and breathing, but it is essential that his mouth must be free, for if there is only a little food in the mouth he cannot speak at all. He is able to smoke. The voice is so clear that it would be difficult to tell from hearing it that there was any abnormality at all. The author thinks that if it could only be possible to obtain such a good result in all cases it would not be necessary to apply an artificial larynx after extirpation. Schmid was of opinion that the soft palate and tonsils form the voice. Landois thought that it was formed in the naso-pharynx. **Michael.**

THOM, ALEXANDER.—(Crieff).—**Tracheotomy in Children; Why Unsuccessful.** *Edin. Med. Journ., September*, 1888.

A RECORD of seven cases in which death occurred after the performance of tracheotomy. The author adheres to the old view that diphtheria and croup are distinct. Six of the cases suffered from laryngeal obstruction due to either of these, and the seventh developed symptoms when suffering from whooping-cough and bronchitis. When the trachea was opened a large piece of membrane was coughed out. All the cases may, therefore, be considered diphtheritic. Dr. Thom discusses the want of success, as he calls it, under four heads:—(1) Unskilful performance of the operation, which, however, cannot be charged against him; (2) too long delay; (3) imperfect after treatment; (4) unsuitability of cases for operation.

In the *Journal* for November, R. W. Parker has an interesting paper in reply. He points out the true *rôle* of tracheotomy, and thinks the operation should not be considered unsuccessful simply because the patient dies. He joins issue with Dr. Thom in regarding croup and diphtheria as clinically distinct diseases. He thinks that in many cases the operation is too long delayed and the after-treatment imperfect, but would regard no case as unsuitable for operation where laryngeal obstruction is a prominent symptom.

[One of Mr. Parker's recommendations in regard to the performance of the operation must be received with some caution. He says that to avoid the dangers of dissecting down to the trachea, he plunges the knife almost directly into the trachea. This may, we believe, be done with some degree of safety by an experienced operator, but we have seen a young surgeon after doing it fail to pass the tube into the trachea, and cause a cellulitis, which ended fatally.] **Maxwell Ross.**

BRAUN.—Fibroma of the Under Surface of the Left Vocal Cord. *Wiener Med. Blatter*, No. 26, 1888.

THE tumour could only be operated upon by perforating the left vocal band with a laryngeal knife and cutting it off this way through an arcuate incision. Five per cent. cocaine could not be used, because it caused suffocation. **Michael.**

MACKENZIE, G. HUNTER (Edinburgh).—**Cases of Endo-Laryngeal Removal of Growths from the Vocal Cords.** *Edin. Med. Journ., July*, 1888.

NOTES of four cases, one of them of considerable interest from the fact that the microscope revealed the presence of malignancy (epithelioma) in what appeared to be a benign growth on the left vocal cord. In considering what ought to be the treatment in such cases, Dr. Mackenzie quotes with approval Fränkel's rule, that when possible the growths ought to be removed by endo-laryngeal means. Should, in the case under notice, the disease become unmanageable by this mode of treatment, the operation he would be inclined to recommend would be thyrotomy, and after a careful examination of the neoplasm and its attachments, resection of the vocal cord, and as much of the thyroid cartilage as might be necessary to thoroughly eradicate the disease.

Maxwell Ross.

BESCHORNER.—On Ventriloquy. *Jahrsbericht der Gesellschaft für Natur und Heilk. in Dresden*, 1887, 1888.

THE author examined a ventriloquist with the following result. During simple respiration and chest speaking there was nothing special. During the ventriloquial performance there was, however, great tension of the soft palate and erection of the epiglottis, preventing a good view of the whole larynx. The vocal cords were pressed against one another, and presented the aspect of the falsetto register, excepting that the larynx was not elevated as in falsetto singing. The combination of these actions produces the special ventricular voice.

CASTEX.—Diagnosis of Cancer of the Larynx. *Société Anatomique, July* 13, 1888.

THIS was the relation of the case of a patient in whom the diagnosis of cancer had been made by a distinguished specialist. The tracheotomy which had been done produced great amelioration, but towards the end of his life the patient began to present signs of softening of the lung. At the autopsy there proved to be a tubercular necrosis located in the cricoid cartilage. **Joal.**

DARIER.—Syphilis of the Larynx and Pachydermia Verrucosa. *Société Anatomique, July* 6, 1888.

A PATIENT with a malignant form of syphilis had had a hoarse voice for four years. The diagnosis of the laryngeal lesion was difficult, since he had besides pulmonary tuberculosis. At the autopsy it was found that all the vestibular region was swollen, mamillated, and verrucous. Many cicatrices were found on the epiglottis, and these were, without doubt, cured syphilitic lesions. On histological examination there was œdema without great embryonic infiltration. This was probably only a contiguous œdema, and not a diffuse syphiloma. In certain ways it resembles the pachydermia diffusa described by Virchow. **Joal.**

GAREL.—Specific Perichondritis Simulating an Acute Œdema, and Combined with a Laryngeal Polypus. *Annales des Mal. de Larynx, &c., June*, 1888.

THE title indicates the nature of the case. **Joal.**

GOUGENHEIM.—Syphilis and Tuberculosis of the Larynx The Diagnosis of the Associated Forms. *Rev. Clin. et Therap., July* 26, 1888.

THIS is a chapter extracted from the new book of this author and Tissier upon laryngeal phthisis. **Joal.**

LARRANZA.—Contribution to the Study of the Laryngeal Manifestations of Rheumatism. *Rev. Clinique et Thérapeutique, June* 21, 1888.

THE case of a man of twenty-seven years of age, who was attacked suddenly with aphonia; the laryngeal mucous membrane was red, the vocal cords were coloured, glazed and defective in tension. The author attributed these symptoms to rheumatism, and thinks this is the first example of aphonia due to this cause. **Joal.**

MOURA-BOUROUILHOU.—New Theory of the Human Voice. *Journal de Ruault, September* 19, 1888.

THE larynx is not a simple musical instrument, but a singing instrument which is played (1) by two lips, like a horn; (2) by two reeds, like a bassoon or oboe: (3) by two cords, resembling a violin or harp. In another memoir, Moura supports the theory that at some moments the larynx resembles a Pandean pipe or whistle, emitting notes in a manner quite similar to these instruments. **Joal.**

GAREL.—Spasmodic Cough resembling Whooping Cough. Cured by Chloride of Methyl. *Annales des Mal. du Larynx, &c., August*, 1888.

THE case of a little girl thirteen years of age, affected with spasmodic cough. The voice was hoarse, the vocal cords rosy red, the glottic functions appeared normal. Different medicaments, especially antispasmodics, had been employed without effect. A strong spray of chloride of methyl, applied to the neck and the upper part of the back, and anterior surface of the neck, cured the condition. **Joal.**

NALTIER.—On Hysterical Mutism. *Rev. Mens. de Laryngol., August and September*, 1888.

THIS is a complete study of the question, of which the author has observed five cases. The author has in his work collected sixty-six cases, making a total of seventy-one. From a conscientious study of all these cases the author draws the following conclusions:—Hysterical mutism, considered up to the present a rare affection, is, on the contrary, tolerably common.

The difference of sex does not seem to be marked, males are as fre-

quently affected as females. It is most commonly the adductor muscles of the larynx and the tensors of the vocal cords which are affected.

Joal.

PLAYFAIR, JOHN (Edinburgh).—**Pin Impacted in Left Bronchus.** *Edin. Med. Journal, May*, 1888.

SPECIMEN shown to the Medico-Chirurgical Society. The pin had entered on May 4th, 1886, and the specimen was obtained in December, 1887, at an examination after death from cancrum oris. **Maxwell Ross.**

NECK, &c.

STORCH (Hamburg).—**Operative Treatment of Cystic Lymphangioma Colli.** *Deutsch. Med. Woch.*, 1888, No. 42.

A CHILD twenty-one days old had a tumour the size of an adult's hand seated on the left side of the neck. It was extirpated, and the child left the hospital nearly cured four days after. **Michael.**

SPRENGEL (Dresden).—**The Extirpation of Cystic Goître.** *Jahrsberichte der Gesellsch. für Natur. und Heilk. in Dresden*, 1887-1888.

THIS was a demonstration of extirpated specimens. The author is of opinion that the operation can be easily performed. **Michael.**

JACCOUD.—Exophthalmic Goître. *Journal Lucas-Championniere, September*, 1888.

THIS was a clinical lecture delivered at the Hôpital de la Pitié, in which the professor insisted on a symptom of great importance implicating a large number of patients with this disorder, namely marasmus, existing to a considerable degree, and presenting the peculiarity of supervening in the course of an affection considered to be entirely neurotic. The existence of this symptom had led to the proposition of the term exophthalmic cachexia. **Joal.**

HUNTER, GEORGE (Linlithgow).—**The Place of Specialism in General Practice.** *Edin. Med. Journ., May*, 1888.

A VALUABLE paper in which the author strongly advocates the more extended use of the laryngoscope and rhinoscope in general practice. A number of illustrative cases are given. **Maxwell Ross.**

REPORT OF SOCIETY.

Edinburgh Medico-Chirurgical Society.

November 7, 1888.

DR. M'BRIDE showed (*a*) a young man suffering from an unusual form of laryngeal neurosis. In the erect position, or when kneeling with his head thrown back, he could only speak in a high falsetto note. The laryngoscopic appearances in this position were those usually seen in the production of falsetto notes. He believed the condition to be due to a defect in the crico-thyroid muscle. This was rendered probable by the fact that electricity and massage applied to it improved the voice, and because when the cricoid and thyroid cartilages were pressed together by the fingers the falsetto note was replaced by a normal voice. (*b*) A woman who suffered from osseous cysts containing air of the middle turbinated bones, causing nasal obstruction. In the one nostril he broke down the cyst, removing part of the walls and the contents; in the other, he contented himself with opening into the cyst and squeezing the walls flat. The result was that in the latter of the two the cyst had refilled. **Maxwell Ross.**

REVIEWS.

A. C. GRÖNBECH.—Naso-Pharyngeal Polypi, especially the Fibrous. *Copenhagen*, 1888.

A VERY thorough review of all the cases of fibrous naso-pharyngeal polypi related in literature, with the addition of thirteen new ones (all with microscopic examinations), collected from hospitals and clinics in Copenhagen, Grönbech only making use of the term naso-pharyngeal polypi for polypi *originating* from the walls of the naso-pharyngeal cavity.

ETIOLOGY.—(*a*) *Sex.* Out of forty-one cases collected by the author from literature, and in the way above-mentioned, where the fibrous character of the tumour was stated by microscopic examination, thirty-six occurred in males and five in females, which shows that females are not so exempt from this disease as is generally supposed.

(*b*) *Age.* In twenty-eight (out of the forty-one cases) the tumours had begun between twelve and twenty-three, whilst in three cases they had commenced between ten and eleven, and in five cases after the twenty-third year. In five cases there was no statement as to the time of the tumour's commencement.

(*c*) *Site.* The tumour originates either from the right or from the left side of the basis cranii, the author not having a single case recorded originating from the middle line. He uses this fact as a strong proof in favour of the hypothesis that the disease is an exquisite morbus adolescentium, because the base of the skull, during the period in which the fibrous naso-pharyngeal polypi most frequently are observed, grows most at its *edges*, where then the active physiological developing process of ossification is favourable to the development of morbid changes.

Morbid anatomy.—In the most recent cases, collected by the author, the fibrous

tumours were found to contain numerous enlarged vessels; these were found in large numbers towards the surface of the tumours, reaching even as far as the epithelial layer, and being here constructed as capillaries; while in the deeper portions they were constructed as arteries and veins, forming often quite a cavernous tissue. The tumours were often found to contain round cells, but these were generally situated only, or mostly, in the superficial layers of the tumour, and their presence was undoubtedly the result of irritation. The epithelial cells covering the tumour were frequently found flattened from the expansion of the tumour. Sometimes the tumours changed their construction when recurring after operation, and the author quotes the case of a man, aged fifty, in whom the tumour removed by the first operation was found to be of sarcomatous structure, but during fourteen recurrences in six and a half years, it gradually assumed the character of fibro-sarcoma, and at last of fibroma.

Symptoms.—Amongst the symptoms of naso-pharyngeal growths, the author describes more particularly drowsiness and sleepiness, which now and then is a prominent feature. In one case, that of a boy aged thirteen, it was found that the patient, during sleep, exhibited the type of respiration known as Cheyne-Stokes respiration. The author considers this phenomenon as due to fatty degeneration of the heart, which was found several times at the post-mortem examinations of his cases, and this organic change of the heart was evidently the cause of sudden death in two cases of his, such sudden death having been related by other observers of naso-pharyngeal growths. Cerebral symptoms, caused by the tumour perforating the cranial cavity, were absent in seven cases with autopsy recorded in literature, and in one of the author's own, where the tumour even occupied the inferior part of the temporal lobe of the brain. In other cases, however, cerebral symptoms were present where there was no extension of the tumour into the cranial cavity.

Treatment.—Although the author has collected ten cases from literature where spontaneous cure was established, he does not think that these cases justify an expectant treatment, and he recommends the removal of the tumour regardless of the age of the patient, and without leaving any trace of the growth. He strongly advocates treatment by electrolysis, quoting thirty-two cases treated in this manner by different operators, of which seventeen, although serious, were cured. He himself treated one case by electrolysis without ever seeing suppuration.

Dr. Grönbech has dealt with the subject exhaustively, and his work is a valuable addition to our knowledge of this comparatively rare disease.

Holger Mygind.

ROUGIER.—Diseases of the Larynx. *Paris*, 1888.

THIS is a French translation of the first edition of Gottstein's work. Rougier has added notes necessary to put the work *au courant* with the actual state of the science, and has repaired certain omissions from works which have appeared in France. The chief additions have been the employment of cocaine, the treatment of laryngeal phthisis by lactic acid, and the surgical methods employed in cancer of the larynx.

Messrs. Boehm desire us to correct the statement that Sozoiodol was invented first by Professor Wagner, of San Francisco. They intimate that it was discovered first by Herr Trommsdorff, and has been subsequently perfected by him, though it is true that Dr. Wagner used the earliest preparations while in Berlin, acting as assistant to Dr. Fränkel.

BRITISH LARYNGOLOGICAL AND RHINOLOGICAL ASSOCIATION.

THE Second General Meeting of this Association was held on November 14th, at the Langham Hotel, London, the following Fellows being present:—Drs. Warren, Wright Wilson, and Vinrace (of Birmingham) J. W. Elliott, J. M. Hunt (of Liverpool), Dr. MacIntyre (Glasgow), Dr. Robertson, Mr. Ellis (Newcastle-on-Tyne), Dr. Donald Stewart (Nottingham), Dr. Davison (Bournemouth), Dr. Hunter Mackenzie (Edinburgh), Dr. Maxwell Ross (Edinburgh), Dr. Barclay Barron (Clifton, Bristol), Dr. Scatliffe (Brighton), Sir Morell Mackenzie, Dr. Walter Fowler, Mr. Lennox Browne, Dr. Gordon Holmes, Dr. Dundas Grant, Dr. Norris Wolfenden, Dr. J. B. Ball, Mr. T. Mark Hovell, Dr. J. Donelan, Dr. Greville MacDonald, Dr. Orwin, Dr. Bond, Dr. Newman, Mr. Percy Jakins, Dr. H. Scott (London), Dr. Philip Smyly (Dublin), and Mr. Stoker (Hon. Sec.).

The chair was taken at three o'clock by the President, Sir MORELL MACKENZIE. The minutes of the last meeting were read and confirmed. The statement of the Hon. Secretary, together with the financial statement, was then read, and it was moved by Dr. Wright Wilson, and seconded by Mr. Mark Hovell, "That the report be accepted and confirmed;" and this resolution was passed unanimously.

The election of Fellows was then proceeded with, and twenty-four new Fellows were admitted to the Association.

The proposed alteration of Rule 15 was then discussed, and it was moved by Dr. Warden, seconded by Dr. Donald Stewart, and passed unanimously, "That the suggestion of the Council be adopted, and the office of Provincial Secretary be discontinued.

The President then delivered his inaugural address, and on its conclusion a vote of thanks to the President was moved by Mr. Lennox Browne and seconded by Dr. Smyly, and was passed by acclamation.

PRESIDENTIAL ADDRESS ON THE PROGRESS OF LARYNGOLOGY.

BY SIR MORELL MACKENZIE, M.D.LOND.

GENTLEMEN,—My first duty on taking possession of the presidential chair, to which your suffrages have called me, is to thank you for the high honour which you have conferred on me. I consider it a much more than a mere honorary distinction to be chosen to preside over such an assembly as this. To be the first president of a Society numbering among its members the foremost workers in the field of medical science to the cultivation of which my own professional life has been devoted, is a dignity and a privilege peculiarly gratifying to me. It will be my endeavour to justify your selection by striving to be something more than

a figure-head—ornamental or the reverse—as presidents have been sometimes known to be.

In discharging the duties of my office, I have to think, not like certain great monarchs, that the eyes of my predecessors are on me, but that I am setting an example and establishing precedents for my successors. The Society whose formal entrance on life we are met here to-night to celebrate is, I feel, destined to play a most important part in the furtherance of our knowledge of diseases of the upper air-passages, and of our ability to prevent and cure them. But the scientific work which it will perform, valuable as that cannot fail to be, is not its only title to independent existence. Our Society embodies in concrete form the development and tendency, the efforts and aspirations, of laryngology. It gives a "local habitation and a name" to the speciality such as it has never yet had before the public eye in this country. The Laryngological Association supplies a bond of professional union among throat specialists in the United Kingdom which has hitherto been wanting. It has, therefore, a double function—the advance of laryngology, and the promotion of proper *esprit de corps* among its professors. Under both these aspects the Society will, there can be no doubt, be of the greatest use to the younger generation of specialists; and I, as representing the older race, who had to fight their way to professional recognition without these advantages, now bid God-speed to the youngest of the medical societies of London.

To us veterans the successful establishment of the Laryngological Association is doubly satisfactory, as it is, if I may say so, a monument of our past labours as well as an earnest of future progress to be achieved by younger toilers. A very few years ago such a Society would have been impossible, not from the lack of objects of scientific activity, but from the want of men. Twenty-five years ago throat surgery was in the hands of anyone who chose to "swab out" the larynx, or, to speak more exactly, the upper surface of the epiglottis, with nitrate of silver. But the invention of the laryngoscope created a new era. The new speciality, of course, became at once a target for the *francs-tireurs* of the medical press to shoot at. The profession would probably have heard of a new religion with equanimity, or of a new vice with interest, but a new speciality was a thing which would not be tolerated.

I shall not indulge in the harmless amusement of flogging a dead horse for your edification. Specialism needs no defence at my hands, and, besides, I have already said all that I care to say on that matter elsewhere. As for our own speciality in particular, it has had the ordinary fate of every great improvement in the healing art since medical corporations have been in existence. The laryngoscope was at first ridiculed as a "toy," then declared to be useless, and finally it was gravely stated, in a leading medical journal, that "without its use throat diseases were perfectly well treated in every general hospital in London." How great a change has taken place since that time can best be estimated by the presence of the distinguished assembly which I have now the honour of addressing. There can be no doubt that laryngology has ceased to be the "poor relation" which it was once thought to be—

it is no longer the Lazarus feeding on the crumbs that fell from the table of the medical Dives who had taken all disease to be his province. It has forced its way to its proper position, and now carries its head as high as any of its sister specialities. It appears to be even in danger of becoming fashionable—at any rate, the number of its votaries has lately been increasing and multiplying with a rapidity which makes one inclined to wonder, with Abernethy, "what is to become of them all."

But however bad for the individual the crowd of competitors may be, it is an unmixed benefit for suffering humanity, for science, and, let me add, for this Society. We do not dread the increase of the laryngological population, nor wish for any Malthus to teach us how to check it; in whatever numbers they come we can find room for them all, and we shall be glad to accept not only their subscriptions, but their contributions to our funded capital of knowledge. Nor do we wish to confine our membership exclusively to specialists. We are ready to welcome all who are interested in the subjects which interest us, provided they are serious workers who can help us in any way. We are specialists in no narrow sense, but wish to cultivate our own corner of the field of medicine with every kind of assistance that may be available. *Fiat lux* is our motto, from whatever quarter the light may proceed; we are not, I hope, so foolish as to accept no other source of illumination than the laryngological lamp.

That the establishment of this Society marks an epoch in the progress of our speciality will not, I imagine, be denied by anyone whose mental vision is unblurred by personal prejudice. The objections which have been raised to its creation in certain quarters are so trivial as hardly to call for serious notice. Thus we are assured that there is no need for our Society, because the British Medical Association was this year graciously pleased to assign a separate section, at its general meeting, to laryngology. But even supposing that this arrangement were permanent, can it be seriously contended that what I may, perhaps, without too much irreverence call a "scratch" assemblage of peripatetic specialists, held during three days in the year in the midst of every sort of temptation to pleasure-making, is sufficient for the discussion of matters interesting to members of our fraternity, for the interchange of scientific ideas, the ventilation and criticism of new theories, the demonstration of new methods of diagnosis and treatment, the exhibition of new apparatus, and the manifold purposes which can only be fulfilled by personal meeting and debate? The suggestion is, I venture to say, one of the worst insults that has ever been offered to laryngology; for it implies that the subject is so narrow as to require only a few hours for the adequate report of the progress made in the foregoing year, with full discussion of all the points involved therein. It is understood that our speciality was constituted an independent section this year in recognition of the excellent work which was done in the Laryngological Sub-section last year in Dublin; but in consequence of the comparative failure of the section at Glasgow, next year laryngology is to be combined with otology at Leeds, an arrangement equally inconvenient to two sets of specialists.

No one has a warmer appreciation of the British Medical Association than I have. There is certainly no medical organisation which has done so much good during the past fifteen years as it has done. Every member must feel proud of the *Journal*, and many of us must look back with pleasure to the great annual medical assemblies we have attended. I myself have the greatest reason to be grateful to the Association, as some of my earliest and most enduring friendships were formed at its pleasant gatherings; but this does not blind me to the fact that such a body is very unsuited to control the destinies of a great and important speciality; so far from the British Medical Association giving us advice, there are many of us who could give very useful advice to the Association. Twenty-five years ago, when I first began attending the annual meetings, there were no lectures at all. The members met in one large hall, and the papers that were read were of a character calculated to interest the whole medical profession. Those who wished to hear certain papers attended the meetings, and those who did not think they should be edified stayed away; but now, owing to the fact that interesting subjects are read in different sections at the same time, those who attend the annual meetings are very frequently prevented from being present at discussions which they would like to attend. Indeed, the multiplication of sections and sub-sections has, in my opinion, enormously diminished the usefulness and interest of the annual meetings. It may be desirable, or even necessary, to recognise such broad distinctions as surgery, medicine, and perhaps obstetrics; but I feel sure that a large number of the profession must agree with me that the undue multiplication of sections is a great drawback. I recollect once attending a meeting of an Otological Section. There were six members in the room; these consisted of the President, Secretary, the reader of the paper, and the surgeon who was apparently present to oppose him (all these four were London practitioners); there were also two young gentlemen who looked as if they were attending a preliminary course of instruction at the provincial hospital before coming to London: and I was myself the seventh victim. After waiting a few minutes and hearing a discussion on the ever-fertile subject, catarrh of the middle ear, I was hesitating as to how I would leave the room without hurting the feelings of my London friends. Signs of distress were actively shown when I made preparations for departure, and the President, a distinguished London aurist, even said, in a stage whisper, "Don't go; there is something very interesting coming on." I yielded to the blandishments of the President, but after another ten minutes, the reader of the paper not seeming to be making much headway, I withdrew, my example being followed by the two young students, who seemed extremely grateful to me for having given them a lead. This is, I believe, a very fair specimen of a meeting of one of the minor sections of the British Medical Association.

In any case, these homely little parties do not give the laryngologists of the United Kingdom anything like the opportunities of personal intercourse, or of that attrition of mind with mind, which are essential to progress.

What, after all, is the advantage of scientific gatherings of all kinds?

Is it not to make workers in the same field acquainted not only with each other's labours, but with each other's person and character? A man's theories can be read, and the value of them can be gauged to a certain extent by the written words; but adequate allowance for the "personal equation" can only be made by those who know the man in his mental habit as he lives, his intellectual temper, his general character, and even his physical constitution. This practical knowledge, so necessary for the proper discounting of dogmatic assertions, sweeping generalisations, and enthusiastic anticipations, can only be acquired by seeing the man and hearing his living voice. This is what makes medical societies the greatest instruments of medical progress; the fire of debate separates base metal from true more quickly and more effectually than volumes of printed criticism. Hitherto, laryngologists in England have been almost without the means of judging of each other's quality, and estimating the value of each other's work. It is ridiculous to say that the general medical societies give them sufficient facilities in this direction; it would be just as reasonable to say that there is no need for journals devoted to the speciality, because the *Lancet* and the *British Medical Journal* can occasionally be induced to publish an article on a laryngological subject. Again, it is quite a different matter to read a paper on a special subject before a general medical society and before a select body of experts. The general society is pleased, no doubt, and possibly enlightened; but it can pass no trustworthy judgment on the work presented to it, which is forthwith buried in the limbo of its *Transactions*, whence it may be years before it is disinterred by some laborious inquirer. Further, a general society is more or less helpless as to the quality of papers on special subjects which may be offered to it. The work of specialists can only be appraised at its true value by their professional peers, that is to say, only by their brother specialists. One not unimportant function of an Association like ours is to winnow the wheat from the chaff, to eliminate the refuse, and preserve the useful matter. Nothing can compensate for the want of the shock of minds which is as the breath of life to scientific societies; and laryngology, no doubt, in this country has suffered from this cause. If our Society does nothing beyond supplying this want, it will amply justify its existence.

The talk about a Laryngological Society leading to "isolation" is the merest claptrap. It is, indeed, the old familiar bogey held up for the terror of the youthful mind in the form of the awful consequences which must follow the divorce of laryngology from general medicine. No laryngologist, so far as I am aware, has the slightest wish to be "independent" of general medicine, any more than the captain of a coasting steamer wishes to be "independent" of navigation. Surely specialists may gather together to compare notes as to details of their work without surrendering the scientific principles which unite them to the general body of their profession. Are members of the Society of Antiquaries in danger of becoming "independent" of general history? Do the members of those highly-specialised bodies, the Shelley or the Browning Societies, run any serious risk of forgetting that there are other poets besides those to whom their chief worship is paid?

These, gentlemen, are the principal objections which I have heard to the foundation of this Society, and it is significant that so far they have only been heard in one quarter; and the voice that utters them has remained without echo, like "the voice of one crying in the wilderness." I need not, it seems to me, pursue the subject further. Whatever objections there may be to its existence, the Laryngological Association has passed beyond the region of argument, and is now a reality which must in future be reckoned with. It remains for all of us to use every effort to make its actual work worthy of the objects for which it has been founded, and of the hopes with which its birth has been hailed.

I fear I have already detained you too long, but I should like to conclude with a few words of advice to my younger brethren, which, coming from one of the pioneers of the speciality (if I may say so without egotism), will, I trust, be considered neither superfluous nor impertinent.

In the first place, I would urgently recommend the younger members of this Association, whilst devoting themselves to our speciality, to continue to practise general medicine or surgery for the first ten years of their professional career. It is impossible that a man can be a really good specialist without possessing a general knowledge of disease; and when I say general knowledge I do not mean such a knowledge as can be obtained in a student's career, or even such as may be acquired by the holding of minor appointments at the termination of the hospital curriculum. What I consider requisite is such a familiarity with morbid processes as can only be acquired by those who are in the habit of using all the resources of their art in combating the great variety of ills which flesh is heir to. In my opinion, only those who have acted as general practitioners for some years, or who have held appointments as physicians or surgeons to general hospitals, are thoroughly equipped for practising as specialists. It is only after thorough knowledge has been obtained in many departments of medicine that learning and experience can be focussed with advantage on a single point.

For those who are thoroughly competent there still remains much work to be done in our special department of medicine. It is true that only a quarter of a century ago our knowledge of diseases of the larynx was limited to what can be derived from the *post-mortem* room, and that the diagnosis and treatment were mere blind groping in the dark. On the other hand, it is hardly too much to say that at the present day laryngology more nearly approaches the position of an exact science than any other division of surgery. Much, however, still remains to be done; and, industriously tilled as our small but fruitful field has been, the younger husbandmen whom I see before me may yet hope to reap a plenteous harvest.

A glance at what has been accomplished will best indicate what still remains to be achieved. Whether we examine the pharynx, the larynx, the post-nasal region, or the nose itself, we shall find in each region that many diseases which three decades ago were practically incurable now readily yield to judicious treatment. Chronic follicular disease of the throat, whether exudative or granular, was at the period I refer to so

troublesome a complaint that, though patients occasionally "got well," the art of the physician had little to do with their cure. When Horace Green introduced nitrate of silver, it was thought that a great discovery had been made; but those who practised in the early days of laryngoscopy can recollect how frequently disappointment resulted from the use of this agent. Now both forms of this disease—a disease, mind you, of remarkable frequency—can be cured with mathematical certainty. Tonsillitis, if treated in the early stage, can now be readily arrested. Catarrhal affections of the larynx, though still claiming all our zeal and attention, are now much more quickly cured than they were a few years ago; and the greater rapidity with which the normal conditions can be restored in cases of chronic inflammation of the larynx has largely prevented those affections from resulting in benign growths; whilst such tumours, when they do occur, are in most cases quickly removed. When we look at the excellent work of Ryland, published some fifty years ago, we can fully appreciate the progress which has been made in recent times. Careful and sound as Ryland's work is, we see how little was really known. We read of laryngeal polypi eighteen inches long discovered only after death. Of course, the almost inevitable fate of such sufferers was death by suffocation. The laryngoscope has banished such cases from the realm of practice, at any rate in civilised countries.

In the case of laryngeal phthisis, the excellent results obtained by Professor Krause and Dr. Heryng have proved conclusively that this disease can be cured; and I urgently invite the younger members of the Society to follow in the path of those distinguished workers. The methods are undoubtedly laborious, and require the greatest industry on the part of the physicians, but the results are eminently satisfactory. I, who have always been of opinion that laryngeal phthisis was, in point of fact, incurable, must now admit that the possibility of cure, even in unfavourable cases, has been fully established. Dr. Heryng, during the last year, has given me the opportunity of seeing microscopical specimens of cured tubercular ulcers of the larynx. Under these circumstances, I feel bound to exhort my younger brother specialists to persevere in endeavouring to cure tubercular disease of the larynx, feeling sure that, though further modification may be made both as regards the instruments and medicaments, yet the lode has been struck, and all that we have to do is steadily to work it out. In the case of cancer there is also an interesting field for further investigations, and it is not impossible that pre-cancerous conditions such as have of late years been recognised in the tongue and breast may exist, and that by carefully watching and treating such conditions the malignant tendency may be prevented from passing into an accomplished fact. Again, in spite of the enormous masses of statistics that have been collected, I do not think that the relation of benign to malignant disease is definitely settled. Thousands of negative cases are as nothing compared with one positive case, and so many circumstances have to be taken into account in each individual instance that in this particular matter it is obvious that statistics are hardly of any value.

Laryngeal paralyses have been carefully studied in recent years, but

though much has already been effected, more remains behind. It must be admitted that the neuropathy of the larynx is as yet very imperfectly known, a fact hardly to be wondered at when it is considered how little the subtler physiology of the organ is understood. The inquiry is a most difficult one, but this should form an additional incentive to ambitious minds.

In diseases of the nose great progress has been made, especially during the last decennium. A polypus, though still trying all our patience, can be more easily, more completely, and more painlessly attacked than ever it was before. The varied morbid phenomena which have been thought to be not infrequently due to diseases of the interior of the nose have in many cases been traced to their particular sources, and a great number of diseases have been cured which formerly almost defied treatment. Amongst those I must mention especially hay fever and paroxysmal sneezing. In the post-nasal region the cure of adenoid vegetations has resulted in the prevention of deafness to such an extent that there are probably at least 100,000 persons now hearing well who, had it not been for Dr. Meyer's valuable discovery twenty years ago, would be hopelessly deaf. In this region, however, there remains a disease which will tax all your energy and perseverance, all your talents and skill to overcome. I allude to the more severe form of post-nasal catarrh. Any specialist who can discover the means to cure this disease will deserve to rank by the side of Harvey or Jenner!

In your future studies I would especially urge on you not to confine your attention to the graver or more out-of-the-way diseases. I feel convinced that there is a good deal to be done in the somewhat uninteresting region of the minor aphonic ailments. Let me remind you that, however dull such cases may be to the doctor, they are quite otherwise to the patient. It is important, therefore, that even the most commonplace affection should be carefully studied. It is the experience of everyone, I suppose, that such cases, trivial as they are, are often the most difficult to cure. May not this be in part due to the very fact that they are uninteresting? Those who are content perseveringly to interrogate Nature in her everyday dress will, I am persuaded, be fully compensated for such courageous humility.

Let me also point out to my younger *confrères* that our knowledge of the relations of the various constitutional dyscrasiæ, such as scrofula, gout, and rheumatism, with affections of the throat, might be developed with great advantage; at present, it must be owned the sacred lamp of laryngology sheds only a "dim religious light" on those subjects.

Further, I would urge upon you that various methods of treatment should be perseveringly tried, and the results, whether good or bad, honestly recorded. I think there is, in the case of complaints which are generally looked upon as incurable, far too great a disposition to fold one's arms and acquiesce in the inevitable, laying the flattering unction to one's soul that our duty to our patient is discharged by attempting to relieve his symptoms. Thus one never really tries to cure a cancer, because one never hopes to be able to do it. Some exuberance of enthusiasm would, I venture to say, be advantageous even in the most

hopeless cases; at any rate, I would have the doctor carry on the battle to the last gasp, by every means his ingenuity can devise. It is only in this way that the secret of coping with these terrible diseases will ever be wrested from Nature. For this reason, among others, I would earnestly impress on young specialists the necessity of keeping themselves well abreast of the progress of their department in every particular. Let them not be satisfied with being merely good "practical" men, jogging contentedly through their professional career with only their own experience to guide them. However large a man's opportunities of observation may be, he should remember that, as Johnson said, "an Athenian blockhead is the worst of blockheads," and should make himself acquainted with what is being done and seen by others. By this the mind is kept open, and premature crystallisation, the penalty of routine, is avoided. This Society will give you opportunities in the direction here indicated, which your predecessors never had; and I have no doubt you will use them to the best advantage.

If, as a specialist of some length of days, I might hazard a further word of advice to my younger brethren, it would be this—to give your attention mainly to pathology and therapeutics, seeking to enlighten darkness and eradicate error in these important matters. I would earnestly advise you to give your attention to these subjects rather than to the invention of apparatus. One may earn some cheap renown, no doubt, by modifying the mechanism of a snare, or applying the electric light in some slightly novel fashion to laryngoscopy; but an ambition that is satisfied with such triumphs can hardly be called "an infirmity of noble minds."

I have here indicated, in the briefest and most cursory manner, only a few of the points on which independent observations and research will be well employed; but there are many others. Do not allow yourselves to underestimate the importance of the field which you cultivate, because it is of limited extent. Small as the larynx is, it is of immense importance, both in itself and in its relations to other parts. These relations can be satisfactorily studied by the specialist. How often is the existence of grave mediastinal disease, such as an aneurism or a solid tumour, first disclosed by the laryngoscope! And, conversely, how often is it the means of dispelling the suspicion that some such formidable condition exists by showing that the loss of voice is merely functional! The little mirror may in like manner give the first hint of serious disease in the brain.

Again, in the case of phthisis, do we not know that the laryngoscopist can often detect signs of danger invisible to others, and give effectual warning which may prevent the onset of the disease? Thus, gentlemen, we may, not figuratively but literally, call ourselves watchers by the gate of life; scientific sentinels whose duty it is to note the cloud when it is still no bigger than a man's hand, and sound the alarm. Surely this is no ignoble function, but a field of activity presenting opportunities for brainwork which may well tax the highest powers and satisfy the most ambitious.

Work steadfastly then, whether the subject be recondite or apparently

trivial. Observe and test everything, and bring your results here to be criticised by your fellow-workers. This will give a definite method and aim to your clinical studies which cannot fail to be fruitful of good. This is not merely a "counsel of perfection," it is a duty incumbent on all, even the humblest among us, who are engaged in building the ark of medical science for the benefit of the human race. No man with the opportunity of making even the most trivial original observation has the right to keep it to himself; it must be added to the common store. I do not think I can conclude my address better than in the words of Carlyle, which have a special application to members of such societies as this over which I have the honour to preside: "Be no longer a chaos, but a world, or even worldkin. Produce! produce! were it but the pitifullest infinitesimal fraction of a product, produce it in God's name. 'Tis the utmost thou hast in thee: out with it then!" I will only add that, however "infinitesimal" your "product" may be, if only it is honestly come by, we shall be glad to welcome it here.

Dr. MACINTYRE opened a discussion on

The Treatment of Nervous Affections of the Throat.

He referred to the causes of nervous affections of the throat, and showed how different the diagnosis was in many cases, particularly in those due to central lesions. It was not always possible to remove the cause, but when possible this should be done. Of late much had been done to remove ailments from the class of functional disorder, and to place them on a satisfactory basis explained by objective phenomena. Thereafter Dr. Macintyre entered into a description of the different methods of applying electricity to such cases. The apparatus required, arrangement of poles, currents best adapted in individual cases were afterwards discussed, and the results of his own experience were given. In conclusion, he referred to those cases due to lesions of the brain and spinal cord, and what might be expected from stimulation of the great nervous centres.

Discussion.

The PRESIDENT (Sir Morell Mackenzie) said they must all feel obliged to Dr. Macintyre for his interesting and exhaustive paper. Those who had practised this speciality a long time must feel interested in placing the application of electricity on a scientific basis. It had been the wish of many of them, and it would be interesting to have the result of the experience of the members present on that subject. He saw before him a number of laryngologists who had given the subject their attention, and he would be glad to hear their views.

Mr. R. ELLIS said he had never measured the amount of the current to be used in what he would not call hysterical aphonia, though the cases alluded to were probably of that nature. It occurred in unmarried females between the ages of 15 and 35, the class in which hysterical affections generally were met with. He thought he could remember a large number of cases in which he had used electricity, and his experience had been very satisfactory. He could not say how it cured, but it did restore the voice if only they could persevere with the treatment. It had, perhaps, a moral effect as well. After two or three applications of shock the patient then rarely failed to get better.

Mr. LENNOX BROWNE observed that their experience of electricity was confined

to the so-called cases of "hysterical aphonia." A large proportion of the cases were simply cases of want of nervous force—of the will, in fact, and the patients therefore lapsed into aphonia. He thought the case quoted was one of great interest. In many of the cases, although there was some effect during the passage of the current, the effect was not permanent. He said that this, the first paper at the meeting, was an admirable one and covered quite new ground. He had anticipated that the question would be treated from a general point of view. To refer once again to the question of ordinary laryngeal aphonia, he was sorry to have to differ from the author of the paper on the question of the introduction of the electrode into the larynx. Nothing was commoner than for patients to be brought who had been submitted to the external treatment without success. He was always sorry to see these cases, because the patients had, so to speak, got used to the current, and then it might do less good internally. He mentioned a case brought to him on the previous day by a doctor, in which the current had been applied externally without effect, but which had recovered as soon as he introduced a laryngeal mirror, a trifle hotter than usual, into the throat. He thought electricity ought to be applied early in the case. He alluded to the remarkable case of a soldier who was dumb as well as aphonic. The man was very anxious to get out of the service.

Dr. DUNDAS GRANT said that in order not to ring the changes too much on the remarks that had been made already, he would confine himself to his own opinions. These sometimes differed considerably from those of his esteemed colleague, Mr. Browne. He was disposed to think the value of the treatment had been overrated. He really felt convinced that the effect was moral rather than stimulating, either as regarded nerves or muscles. In applying the faradic current to the interior of the throat, he supposed one wished to provoke a closure of the larynx, yet in not one case out of twenty would they place it where it was required. The posterior wall would generally be touched. He did not wish to make too much of that point, but he could not help thinking that the greater effect that was claimed for the application to the interior of the larynx was due to the fact that the shock was more marked when applied to the mucous membrane than when applied to the skin. The great point was not to find out some new way of applying electricity so much as to distinguish the cases in which it was desirable to apply such a severe form of stimulation. One saw cases occasionally where the effect was very tangible, but tended to make matters worse rather than better. Those were cases in which the aphonia was not purely a nervous phenomenon, but was associated with some thickening of the mucous membrane. Those cases ought to be examined beforehand. There were many other things connected with this aphonia besides the mere want of power of the adductors. They must go behind the muscles and nerves, and get to the will which was wanting. The great test he made use of was to see whether the patient could give a good strong phonetic cough. Before resorting to shock he always tried to make the patient run her cough into an intonation of the vowels. That was a little exercise which it was easy enough to get them to do. Sometimes one got the patient to intone the vowel "A," and in that way bring about a recovery of the voice, without resorting to the more unpleasant method of electricity. In other cases, the difficulty was that the patient was not able to co-ordinate the breathing with the approximation of the cords. In such cases, and he had had two or three of them, he had endeavoured to instil the principles of breathing as described by Emil Behnke, and that was one among many other means which should be adopted without immediate resort to electricity in that particular class of case. The class of cases in which one would like to see

electricity thoroughly tried would be those extraordinary occurrences of myopathic wasting of the adductors of the vocal cords. He looked forward to being enabled to prevent the rapidity of the wasting of those muscles, and so prevent them from going on from bad to worse. He remembered a case in which, whether from misadventure or not, the pneumogastric nerve had been damaged, and by examining them not less than three times in twenty-four hours the difference in the size of the posterior crico-arytenoidei was most unquestionable.

Mr. MARK HOVELL thought there could be no doubt that more cases were cured by the internal than by the external application of the electrode; the cases in which the external method was efficacious were those in which some stronger application had been made to the larynx. He said it did not matter what the case was, but the internal application was certainly more powerful. With regard to the cases in which there was wasting, he found that the combined current was better than either form applied separately.

Mr. KENNETH MILLICAN thought that too little attention was paid to the use of the continuous current. His own experience led him to the conclusion that in those cases in which the pearliness of the cords is lost, and where there was some thickening dependent upon some past congestion where the attack of hysterical aphonia had taken rise, the resolvent and chemical effects of the continuous current had always appeared to him to be produced. He had seen cases fail with faradism when the continuous current proved to be successful. He thought there must be a good many cases where the essential difference in character between the two currents would be useful in the application of electricity to the larynx, especially in cases of wasting of the muscles, which of course was parallel to the ordinary wasting from peripheral paralysis in any part of the body consequent on an interference with the nerve supply. Those cases were, of course, not benefited by faradic electricity, but were benefited by the constant current, and he thought that kind of current was distinctly indicated in that class of cases.

Dr. STOKER said that like those who had spoken that evening, he had not much to add to the very exhaustive paper of Dr. Macintyre. His object in speaking was to express his agreement with him. With respect to functional aphonia, he thought it was clear to everybody who had treated these cases, and who had listened to evidence on the subject, that there were some cases which they could treat with the external current, and that many of them, on the other hand, resisted external application, and they were obliged to turn to the internal application. He thought it was a clear, concise rule, that in cases of functional aphonia not associated with tissue changes they should try first the external, and then, if necessary, the internal, application. The effect in either case was essentially of a moral nature, as was borne out by what Mr. Browne had said, and was also proved by the fact that the introduction of the ordinary laryngeal mirror was often sufficient to restore the voice. This could not be due to any effect on the nerve alone, or on the muscle alone, but to the moral effect. The patient was considerably surprised, and forgot about the aphonia, and cried "Oh!" and having said it once was inclined to go on saying it. Dr. Macintyre alluded to various theories which had been advanced by his colleague, Dr. Woakes. But although he did not go as far as Dr. Woakes in the necrosing ethmoiditis theory, he thought there was a good deal in what he had advanced. He thought there was probably no nerve in the body which had such accessible mucous connections as the fifth nerve, and no nerve more intimately connected with the sympathetic and vaso-motor system. In applying irritation (electricity), of whatever kind that irritated the fifth nerve, they had considerable effect on the vaso-motor system. Their President had said that it was very desirable that the younger members of the

speciality should apply themselves to the treatment and practice of simple diseases. He ventured to recommend that in these cases of simple pharyngitis It was a very efficacious plan to apply the electrical current. He did not say that it had either a chemical or resolvent effect, but he did think that in applying it to those parts of the mucous membrane supplied by the fifth nerve, they were producing a marked effect on the vaso-motor system, and so on the vessels of the throat. As an instance of this vaso-motor power, he mentioned that he had then two cases of goitre which had been cured after everything else had failed, by the application of electricity and of the cautery to the nose, to the external nasal branch of the ophthalmic division of the fifth. He followed and entirely agreed with Dr. Macintyre with regard to the dosage of electricity. He thought it was very desirable that the dosage should be small and frequent. That system of dosage was not confined to electricity, it was coming to be recognized in drugs as well.

Dr. NORRIS WOLFENDEN said they had been speaking of various kinds of aphonia, some of which were benefited by moral treatment while others were not so benefited. He thought that a great many of these cases which were supposed to be functional were due to paresis of the crico-thyroid muscles. That led to a want of tension of the vocal cords, and these cases benefited by the external application of electricity applied over the muscles in question. There were cases in which the moral effect was desired, and then electricity might be applied to the skin anywhere. He wished to call attention to the value of electricity in the treatment of post-nasal catarrh. He remarked that he had had very good success in the treatment of obstinate dry catarrhs of the naso-pharyngeal cavity by applying a mild current frequently, and for only a few minutes. It was necessary for the success of the treatment that it should be carried on over a very long period of time ; but, of course, any treatment of these catarrhs required time for success. Patients, therefore, sometimes objected to that plan of treatment ; but if properly carried out, with the object of improving the nutrition of the muscles and tissues, they would meet with success. Dr. Stoker had mentioned an important matter about the disappearance of goitre under the influence of the electricity. He did not know whether Dr. Stoker meant the application of the current or the cautery. (Dr. STOKER—Both.) He thought there was a good deal of nonsense talked about the sympathetic. Hack's theories were very vague, and in many points opposed to physiology. We are not in a physiological position to say that there was any ganglion which was itself a centre of vaso-motor action. All those phenomena were central, and the very sympathetic system about which so much is said is only an offshoot of the cerebro-spinal system, and is in no sense independent physiologically. He had himself tried the application of electricity to the nose in cases of exophthalmic goître, not with the hope of doing any real good, but for the purpose of testing the observation of Hack. He did not suppose that any good would result from applications of electricity to the nose in ordinary goître. He thought it would be interesting if Dr. Stoker would give them the history of the cases mentioned by him, and exhibit them. Ordinary goître and exophthalmic goître were two different diseases, one was central and the other local. Hack asserted that he had cured exophthalmic goître by applying the galvano-cautery to the nose ; it may be that the effect was only temporary. In three or four cases of exophthalmic goître, of which he had seen a good deal, he had applied the cautery to the turbinated bodies and had seen the tumour diminish half an inch, the diminution lasting for a fortnight ; but the effect had never been permanent. He never, indeed, expected to see any permanent effect. The way in which the temporary alteration in size was produced was probably by applying a violent

stimulus to the central nervous system, and particularly the lower cerebral centres, which were chiefly affected in exophthalmic goître by way of the fifth nerve.

Mr. LENNOX BROWNE asked Dr. Wolfenden how he applied the electricity in post-nasal catarrh?

Dr. WOLFENDEN, in reply, said that he generally used the constant current. The faradic current sometimes caused bleeding and pain. He used an ordinary laryngeal electrode wrapped with cotton wool, moistened with water or salt solution. He always measured the strength of the current first with the resistance coil and galvanometer. The strength used was from three to four volts at most. He applied it to the back of the pharynx, introducing the electrode through the mouth, and gently brushed the mucous surface with the electrode.

Dr. STOKER said that he was unable to find the case referred to in Hack's works.

Dr. WOLFENDEN said that it might not be in his large work, but it had been reported in all the journals devoted to laryngology at one time or other.

Dr. MACINTYRE, in reply, said he had very little to say. He regretted that the discussion had been narrowed to the subject of hysterical aphonias. He said that it was evident that electricity needed to do more than stimulate a muscle or nerve in order to lead to recovery of the voice. It ought to be used in the cases mentioned by Dr. Grant, such as pressure on the vagus leading to wasting. It was very difficult to explain the moral effect. Why was the moral effect not the same when applied externally as internally? He wished to give a case in point. He saw a case of general paralysis of the limbs which came on quickly in a woman the other day, in which the two upper extremities were completely paralysed. Placing the woman in a warm bath had the immediate effect of removing the paralysis, and in a few minutes she could move both arms. He had her put in the bath again and placed a strong current to the lower limbs, and in ten minutes she began to move the legs. There was no moral effect in this. It was simply a stimulus. The question was a much more complicated one than might be imagined from the local conditions. The object of the paper had, however, been attained.

On Anosmia. By J. DUNDAS GRANT, M.A., M.D.

THE loss of the sense of smell, though weighing less on the minds of the sufferers than the loss of sight or of hearing, is certainly of sufficient importance to justify the President in proposing it as a subject for discussion by the Association. Its full consideration carries us beyond our special sphere into that of the neurologists, but such consideration is necessary in order that we may recognise causes of anosmia behind or apart from nasal disease, and that we may not deter sufferers in appropriate cases from obtaining in time the aid of those most skilled in the diagnosis and treatment of nervous diseases. This is one of the many instances in which the co-operation of workers in the different fields of medical practice is necessary for the greatest good of the greatest number of patients.

Smell must be distinguished from the sensation produced by the contact of pungent or irritating vapours with the Schneiderian membrane, and which affects the domain of the fifth nerve. On the other hand, it includes many of the sensations commonly ascribed to taste; in fact, all specific flavours apart from those of saltness, sweetness, bitterness, and sourness. In disease of the fifth nerve[1] irritant vapours are not perceived,

[1] Althaus, *Med. Chir. Trans.*, 1869.

though perfumes may be perfectly distinguished; but in disease of the olfactory nerve[1] the contrary is the case, and the perception of all tastes beyond those above-mentioned is abrogated.

Among other interesting and important points connected with the sense of smell is the great practical fact that whatever it be that issues from the odorous substance, it must come in direct contact with the olfactory portion of the nasal mucous membrane. The most odorous bodies are volatile rather than soluble,[2] and the emanation from them is probably gaseous[3] rather than solid, as it can pass freely through cotton wool; and the fact that odorous substances are not readily smelt when solutions of them are poured into the nostrils indicates that the emanation is not in a liquid form. The character of a smell seems to be pronounced in proportion to the height of the specific gravity of the substance.[4] As the vibrations of the particles are slow in proportion as the specific gravity is high, there is thus strong evidence that excitation of the olfactory nerve-endings is brought about by the vibrations of the particles of the odorous substance. This being established, it is obvious that anything interfering with the access of vapours to the upper part of the nasal cavity—namely, the surfaces of the middle and upper turbinated bodies and roof of the nose—where the olfactory nerve-fibres are distributed, will interfere with the sense of smell. Of such causes of obstruction none in the writer's experience are more potent than the presence of nasal polypi. They project very frequently from the under surface of the middle turbinated bones, and tend thus to occlude the passage between those bones and the septum as well as to encroach upon the upper part of the vestibule, so as to prevent the access of vapour to the olfactory region.

Chronic hypertrophic rhinitis is less frequently associated with anosmia, as it does not tend so much to occlude this passage. Fränkel[5] found anosmia present in only three out of seven cases. The middle turbinated bodies may be even very considerably hypertrophied without inducing this effect. Deviations of the septum certainly contribute largely when well marked, and the writer considers that vertical deviations are more potent in this respect than those which are horizontal. Foreign bodies, rhinoliths, and other obvious obstructions may produce the same effect (as may the swelling of the mucous membrane in an ordinary "cold in the head"); and Cozzolini describes a case of coryza caseosa, in which smell was completely in abeyance owing to the blocking of the nasal passages.

It is chiefly by the upper part of the vestibule that odour-laden air is inspired during the act of "sniffing," which is essential to perfect olfaction, and the exercise of the function is materially interfered with by any condition preventing the performance of the necessary facial movements. Such a condition is facial paralysis, and the effect is illustrated by a case under the writer's care, in which a sarcoma involving the right *portio dura* has completely incapacitated the patient from sniffing, or

[1] Ogle, *Med. Chir. Trans.*, 1870.
[2] Valentin, *Internat. Centblatt. f. Laryngol.*, 1885-86, p. 152.
[3] Ramsay, *Nature*, June 22, 1882.
[4] Haycraft, *Proc. Roy. Soc. Edin.*, May 2, 1887.
[5] *Deutsch. Med. Wochenschrift*, 1884, p. 274.

appreciating odours by means of the nostril of the affected side. Similarly, the act of sniffing is ineffectual in cases of destruction of the outer portion of the nose, as the blast is not directed upwards to the olfactory region, and smell may be restored by the application of an artificial substitute.

Affections of the olfactory mucous membrane are common causes of anosmia, as we see frequently in cases of atrophic rhinitis. Possibly the dryness is to some extent answerable for this result; but in all probability the abnormal condition of the epithelium has still more to do with it. The habitual use of astringent nasal douches probably produces its deleterious effect on smell by injuring the epithelium.

Among other conditions of the mucous membrane essential to olfaction is the presence of pigment in the cells. Ogle[1] and Althaus[2] quote cases bearing on this point, and in a case of congenital anosmia recently seen by the writer, the pallor of the olfactory portion of the mucous membrane was most striking. Exner[3] found arrest of development of the pigment after section of the olfactory nerve; and it is stated that albino fox terriers are exceedingly deficient in smell and hearing. The olfactory nerve-fibres passing through the cribriform plate are apt to be ruptured through injuries to the head, and Dr. Ogle[4] cites several cases of anosmia from this cause. Following the olfactory nerves backwards, we next reach the olfactory bulb, the microscopic structure of which has considerable analogy with that of the retina. That this part is associated with smell[5] is proved by Schiff's and Vulpian's experiments. As Bernard suggested that olfaction might be a function of the fifth nerve, Prévost removed Meckel's ganglion without producing any loss of smell. Comparative anatomy gives similar evidence; but Bernard's case of absence of the bulb and absence of perforations in the cribriform plate, with authenticated capacity for smell, seems to admit of no other explanation than that of a vicarious action of the fifth nerve. In a case published by Lebec and Duval,[6] however, where the same condition appeared to be present in an individual with unquestionable olfactory power, the external root of the olfactory tract was present, and olfactory nerve-fibres were seen in microscopical examination of the olfactory mucous membrane. The assumption was that the continuity of the tract was maintained by means of fine fibres, which were destroyed during the removal of the brain.

Cases of lesion of the olfactory tract have been published by Kahler,[7] Story,[8] and Althaus.[9] The last describes acute olfactory neuritis in an ataxic patient, who for six weeks experienced a phosphorous smell, and then lost the sense completely. There was sensitiveness of the mucous membrane to irritating vapours, but loss of appreciation of perfumes, and

1 *Op. cit.*
2 *Lancet*, May 14, 1881.
3 Althaus, *Op. cit.*
4 *Op. cit.*
5 Duval, Althaus, *Op. cit.*
6 *Archiv de Neurologie*, 1885.
7 *Internat. Centbl.*, September, 1887.
8 *Dublin Journ. of Med. Sci.*, July, 1884.
9 *Op. cit.*

of all flavours apart from those of saltness, sweetness, bitterness, and sourness. Althaus and Holm[1] give cases of anosmia arising from syphilis.

The centre for smell may be the seat of conditions leading to anosmia. It has been experimentally localised by Ferrier[2] as in the anterior part of the uncinate, or hippocampal, convolution. Broca[3] and Zuckerkandl,[4] from clinical and anatomical researches, respectively give support to this view, as do also such cases as one of epilepsy with olfactory aura,[5] in which a patch of softening was found in the region described. In another case, characterised by sensations of smell,[6] a tuberculous tumour was found in the right occipito-temporal and hippocampal convolutions. Dr. Churton[7] published a case of right-sided anosmia, in which a tubercular tumour was found invading the right uncinate convolution. Hughlings Jackson and Ogle[8] have brought forward cases of aphasia, right-sided paralysis, and left-sided anosmia, and it seems to be the rule for the anosmia to be on the same side as the lesion; but Gowers quotes a case of Demange's,[9] in which there was disease of the convexity and (among other symptoms) opposite-sided anosmia, indicating a centre on the convexity, or at least a communication from the convexity, through the internal capsule, with the opposite olfactory centre. M. Féré[10] publishes a case which gives evidence of a similar decussation.

In addition to the mechanical and the organic causes of anosmia already mentioned, there remain some functional and toxic causes of considerable interest and importance.

Hysteria (whatever it may be) has occasionally as one of its manifestations a one-sided loss of smell or hemianosmia. Over-stimulation of the olfactory nerve as a cause is typified in Dr. Graves's classical case,[11] of a cavalry officer, who, after, superintending the clearance of a pit full of fœtid material, lost his sense of smell, and had not recovered it thirty years after. Wagner[12] cites the case of a flour-dealer, who, apparently through long-continued exercise of his olfactory sense, for judging of the quality of the material he dealt in, lost that sense absolutely for this particular purpose, though not for other purposes—a technical olfactory paralysis. Dr. Bryce's[13] case of loss of smell from continued exposure to bisulphide of carbon, and Dr. Havilland Hall's[14] case of temporary anosmia, due to the smell of carbolic acid, may be looked on as examples of specific poisons, but more probably as instances of the result of over-stimulation. Lead poisoning, which is known to be a cause of atrophy

1 *Internat. Centbl.*, vol. iii., p. 283.
2 *Functions of Brain*, 2nd ed., p. 321.
3 Ferrier, *Op. cit.*, p. 313.
4 *Monatsschrift für Ohrenheilkunde*, 1887, p. 132.
5 McLane Hamilton, quoted by Gowers, *Dis. of Nervous Syst.*, vol. ii.
6 Carbonieri, *Internat. Centbl.*, August, 1887.
7 *Brit. Med. Journ.*
8 Ogle, *Op. cit.*
9 *Op. cit.*, p. 18.
10 Gowers, *Op. cit.*, *Archives de Neurol.*, 1885, p.
11 Gowers, *Op. cit.*, p. 131.
12 *Intern. Centbl.*, vol. i., p. 140.
13 *Edin. Med. Journ.*, August, 1886.
14 *Westminster Hosp. Rep.*, vol. i., 1885.

of the optic nerve, is probably an occasional cause of anosmia, as in an unpublished case of Mr. Lennox Browne's of a lady who lost her smell after the prolonged use of a hair dye containing the metal in question. Paul[1] and Neyel[2] publish cases in which the arthritic dyscrasia was inculpated ; but in the latter case there was evidence of a strong neurotic tendency, a factor of not inconsiderable weight. I have already alluded to its connection with syphilis tuberculosis and locomotor ataxy as a symptom of one or other of the associated morbid changes.

We may summarise the causes of anosmia already referred to as nasal obstructions, facial paralysis, abnormalities of the olfactory epithelium and nerve fibres (loss of pigment, &c.), rupture of olfactory nerves, congenital absence of olfactory tracts, and disease (inflammatory, &c.) of these parts, disease of the centre for smell on the same or on the opposite side (tuberculous, syphilitic, &c.), hysteria, various poisons, over-stimulation, and over-exercise of the sense.

In the diagnosis the activity of the sense must be tested by means of irritating perfumes sufficiently familiar to the patient for ready identification. At the same time the presence or absence of the appreciation of different flavours (apart from pure taste proper) must be considered. As a general rule, loss of smell without impairment of taste for flavours (as distinguished from taste proper), indicates local nasal obstruction. Local nasal causes (especially polypi) must be eliminated before the rarer forms of nervous anosmia are diagnosed. The writer has no experience of the use of the continuous current as a test, and Dr. Althaus[3] points out the great objections to its general use. The traumatic, toxic, and neurotic causes must be kept in mind. Lastly, the central causes can only be diagnosed by means of a neurological analysis of the accompanying cerebral symptoms.

As regards the prognosis, it obviously depends in most cases on the removability of the cause ; but the question remains as to how long the nerve may remain functionally inactive without undergoing permanent degeneration. Sir Morell Mackenzie considers two years as the greatest length of time compatible with recovery ; and this may be taken as a fair criterion. It is desirable that the experience of members of the Association and of the profession in general should be forthcoming on the subject.

In the same way the treatment must be carried out on the lines indicated by the cause. The various methods of removing nasal obstruction were fully treated by the author at the last meeting of the British Medical Association. He would, however, add that electrolysis had been of permanent value in some cases where caustics had failed to prevent recurrence ; and in one notable case where the extensive and dense hypertrophy of the middle turbinated bodies had for more than a year destroyed the sense of smell, the use of the electrolytic current had brought about a lasting diminution of the swellings and a restoration of the sense.

In many obscure cases the question of a comparatively curable syphilitic

[1] *Bull. de la Soc. de Thérap.*, 1885.
[2] *Prog. Méd.*, April 24, 1886.
[3] *Op. cit.*

lesion being the origin of the condition arises. Remembering, also, the beneficial effects of iodide of potassium in lead-poisoning and in the arthritic dyscrasia there is encouragement to make a tentative use of a drug of such value when judiciously administered.

For anosmia of functional or neurotic origin, the remedy of most value is strychnia, and it may be given internally or as snuff, but preferably by the former method.

A case of unexpected sudden recovery of the faculty of smell after removal of an elongated uvula was communicated to the writer by Mr. Lennox Browne, but it seemed a question as to whether the sequence was the result of relief of nasal hyperæmia following the operation, or simply the effect of the shock.

In conclusion, it is hoped that the ventilation (however imperfect) of this interesting subject may lead to the formulation of definite views concerning it, founded on the large amount of floating experience which is necessarily possessed by the profession at large.

Discussion.

The CHAIRMAN said he was sure everyone present must have been deeply interested in Dr. Grant's paper. The subject was a very extensive and interesting one.

Mr. LENNOX BROWNE said he might refer to one or two points of interest in a case of anosmia cured by the abscission of the uvula. He felt that the evil was in the relaxation of the soft pharynx. It seemed that the irritation was upwards and forwards. The irritation was relieved by the removal of the uvula, and the relief of the irritation was the cause of the restoration of smell. His experience led him to go a little further than Dr. Grant in regard to polypi. He took it that moisture was necessary to the sense of smell. He found that in a number of cases. One point in regard to the question of moisture was that in albuminuric retinitis they found loss of the sense of smell. He had seen an interesting case a few days ago. It was the case of an Indian officer who had broken the upper portion of his nose just above the bridge. He was quite conscious that he had lost the sense of the appreciation of the bouquet of wine and the finer sense of smell; but it was only recently that he began to develop more acutely the defect in the sense of smell. A portion of the inferior turbinated bone came away, and then it was that he began to know that the sense of smell was impaired. From that it was clear to him that there was a fine dividing line between the sense of smell, and that portion of the sense of smell which related to taste. He believed that when his catarrh (?) was cured he would have a very fair sense of smell, although he would never be able to use it as a wine-taster or as a tea-taster, which required a very delicate sense of smell. As to the question of cocaine, he had seen a few cases where the frequent use of cocaine had led to an increase of the sense of smell. He examined some years ago several cases of paralysis of the insane, and also found cases in which locomotor ataxy was combined with anosmia. With reference to rhinitis caseosa he had recently a peculiar case. This patient used to have a most disgusting occasional secretion from the nose, of a putrid character, which he used to scrape away. He succeeded in curing this discharge and restoring the sense of smell. He found that polypi only interfered with the sense of smell when they were associated with the superior or middle turbinated bone. They often had cases of polypi that came under their care which really depended from the lower surface of the turbinated bone, and therefore did not interfere with the sense of smell. These are cases where the nose is blocked, though there is no interference with smell. He

hoped these papers would at least make them think and see whether really they could not assist the neurologist by some direct clinical observations from the position of the rhinologist.

Dr. BOND said they were all indebted to the writer of the paper. They had had an exhaustive enumeration of the various causes of anosmia, whether local other. There was a simple classification which would assist him in making clear the few remarks he had to offer. In examining cases of anosmia at the different special hospitals, they found two classes of patients. They found one class of sufferers that was very limited. The other class was a very large one, and consisted of numerous cases of hypertrophic rhinitis and polypi. In the first class he thought the most common conditions of patients complaining of these troubles, consisted of polypus of the middle spongy bone, far back and high up. He had seen several of such cases recently. Latterly he had met with one rare condition,—a girl of 23, anæmic, and in whom there was not much local discharge from the nose, and only a little pallor. There was this history—a very common one. She had lost her voice, which rapidly re-appeared under treatment. Now, she had anosmia, both sides of the nose being equally affected. He thought it was a case of hysterical anosmia. He thought it was truly hysterical, and doubted whether it was curable.

Dr. WRIGHT WILSON said that in 1887 he had an unfortunate experience. He was laid up with blood-poisoning. He lost the sense of smell entirely. A neighbouring practitioner attended, and advised small doses of iodide of potash. He got coryzic inflammation of the nose, and it became stopped altogether and had to be discontinued. But a curious circumstance was, that his father lost his sense of smell at the age of forty-three, from erysipelas of the face and nose.

Mr. MILLICAN said there was one case he would like to mention. It referred to one form of anosmia which had not been touched upon—viz., anosmia due to reflex causes. In 1886 the wife or a very well-known surgeon came under his treatment for loss of smell and taste. She used to suffer very badly from menorrhagia and hæmorrhoids, and these were treated and cured, when forthwith she began to suffer from nasal discharge, which smelled very badly, and coryza. Sometimes there would be cough and loss of smell and taste. He saw nothing abnormal except that she was very constipated. He attended her from the 5th of June to July 2nd, when he lost sight of her altogether. When he next heard of her in October, she had a smart attack of diarrhœa from mackerel-poisoning, and smell and taste returned and had remained in good condition ever since. He should have liked to call attention to the sympathy between the rectum and the alimentary canal, and also to the collateral symptoms and irritation of the nasal cavity from ascarides and other causes.

Dr. G. MACDONALD would venture to urge the differentiation between smell and taste. He himself had arrived at this discrimination : clinical observations made by him showed that the middle turbinated bone was specially reserved for the sense of smell, while the superior turbinated was connected with the sense of taste. Quite recently he had had two cases of nasal polypus, one affecting the whole of the middle turbinated body, and the inferior and upper surfaces, the second case being confined to the under surface. There was complete loss of smell in both cases. Both patients had also said that when they smelled—when they drew in the air to smell, they could taste a thing but could not smell it. The upper turbinated body was free from disease, while the middle showed traces of disease. The anatomical description of the olfactory nerve would perhaps justify this discrimination, seeing that it is divided in the nasal cavities into two main divisions. The anterior division was distributed to the upper surface of the middle turbinated and the septum, while the posterior was distributed to the

superior turbinated. The posterior had relation to the sense of taste, the anterior to the sense of smell.

Dr. WARDEN said there appeared to be a condition in anosmia which led to a perversion of the senses of taste and smell. He had a lady under his care who suffered not from loss of smell or taste, but from a modification of it. She suffered from morbid taste and smell. She was staying at a sea-side hotel, when she experienced a very disagreeable odour and became very unwell; she was attacked with diarrhœa and sickness, and was so ill that it was feared it would be impossible to get her home. From that day to the present time her sense of smell and taste had not been absent, but so perverted that any food she attempted to take (she took no solid food) produced a most disagreeable effect upon the nerves of taste and smell, and it became quite obnoxious to her. Anything like the smell of game would become so disagreeable to her as to be almost unbearable. Any particular kind of scent was intensely disagreeable. He thought there must be a positive relation between anosmia and depraved taste and smell. The lady in question unfortunately was also very susceptible to iodide of potassium. He found that a half grain dose would produce the most inveterate coryza, and cause such illness that it was positively unbearable. Nothing seemed to have any marked effect. For the last twelve months the patient had taken no solid food, but had lived on suction as it were.

Dr. W. HILL said that his experience led him to the conclusion that where there was a want of secretion there was a want of smell; also if there was too much secretion. His impression was, that in these two conditions they had an explanation of most cases of anosmia in nasal disease. Smell was associated with contact of the odoriferous particles, whether aerial or solid, with the endings of the olfactory nerves. Unless these endings had contact with the odoriferous particles there could be no smell. If, therefore, there was polypus, in which there was excessive secretion, we must have anosmia, because then odoriferous particles could not come in contact with the nerves. As far as his experience led him, he believed anosmia was rather rare in comparison with other diseases of the nose. But that nasal obstruction and higher secretion caused anosmia there could be no doubt. He regarded it as a bad symptom in rhinitis if the cells were destroyed, for then they would get permanent anosmia. If they only got a small morbid secretion, they could remove the cause.

Mr. LENNOX BROWNE said loss of smell was not due to loss of secretion, but to tumefication. In anosmia there was deficient fluid.

The CHAIRMAN said he had always thought the subject of anosmia a very interesting one; but he had always found that it led to the telling of a great many anecdotes. They were very interesting, and no doubt instructive; but it was a question whether in the end they derived very much from them. He said that, as regards the perversion of the sense of smell, he had had a case almost like Dr. Warden's, of a lady who suffered from the greatest perversion of smell. The smell of meat always made her ill. He had seen also a case of anosmia cured by excision of the uvula.

Dr. GRANT remarked in reply that in one very curious instance of deprivation of the sense of smell he had used cocaine with advantage. He recently tried to test whether the application of cocaine would not aid them to blunt the sense of smell. He did this expecting to show a result very promptly; but he found that after the cocaine had been removed, which had been allowed to remain longer than he intended, it happened that the patient got to smell better. He thought there were certain associations between the nose and other organs—with the uterus, etc., which might account for some cases of anosmia. He was quite sure that chronic atrophic rhinitis was not unfrequently associated with uterine disease, and he the

other day suggested at Glasgow that he had seen cases of fœtid rhinitis which disappeared from young girls after they had got married. There was room for further investigation in regard to the symptomatic relations of anosmia. Dr. Macdonald's observations were extremely interesting and were conclusive, and he should look after such cases in his own practice. The question was, what was meant by taste and smell, whether in those cases of anosmia there was not really a confusion of terms on the part of the patient, or whether there was any distinct sensation? At the same time the fact was most interesting, and with the further correspondence with the condition of the olfactory nerve was most interesting. Dr. Warden had brought up another point of great value, and that was the association of smell with memory. He had read somewhere of this association. He should be disposed to interpret his case in this way: this was the memory of an offensive smell, which would become permanent in the patient, who was of a neurotic temperament. He was of opinion that the chief thing for the relief of a case having such indications would be to improve her general condition, especially the nervous system by the judicious use of bromides. With regard to Dr. Hill's remarks on coryza, there was no doubt, he thought, that the amount of secretion had not so much to do with it as the swelling. They saw that the portions of the odorous materials that reached the nose were in a condition of sublimation, and they became precipitated in the moisture of the membranes, and they set up a pitch of smell peculiar to themselves.

On the Influence of Certain Medicinal Agents upon the Bacillus of Tubercle in Man. By G. HUNTER MACKENZIE, M.D. (Edinburgh).

THE author of this paper made some preliminary observations upon the conditions which accompany the presence of tubercle-bacilli in the respiratory organs and tissues, and upon the prospects of patients with tubercle-bacillary sputa. Basing his observations upon a number of cases which had been under his almost continuous care for years, he proceeded to show that the presence of tubercle-bacilli in the sputum is not, *per se*, a grave indication so far as life, and even tolerably fair health, are concerned. They do not necessarily cause pyrexia: their association, however, with fever and loss of body weight he considered an ominous circumstance. A few bacilli with fever are of more grave significance than many bacilli without fever. When tubercle-bacilli settle down on the larynx or pharynx the gravity of the prognosis is greatly augmented. In reference to the influence of medicinal agents, the author recounted his results in a series of cases which had been subjected to climatic and to local and general treatment. Regarding the influence of climate upon these organisms, he called attention to two facts—the obstinate persistence of the bacillus, and the remarkably small amount of difference between the anti-bacillary virtues of the most diverse climates. The climate which had given most promise of proving inimical to their growth is one which is dry, with the minimum variations of temperature, which ought to be rather low than high. One beneficial aspect of a low temperature is its tendency to diminish the amount of expectoration, a result which almost always accords with a diminution in number of the bacilli. The influence of general and local remedies, the latter having been principally used in cases of laryngeal phthisis, and consisting of insufflations, sprays, and inhalations, was found to be absolutely *nil*; for the bacilli persisted, and even occasionally increased

despite the most careful local and general treatment. In one case in which an oro-nasal antiseptic respirator was used for eight to ten hours daily for about twenty months, the bacilli were noticed to decidedly increase in number during the period of treatment. The author had come to the conclusion that as yet there was no evidence to warrant us in assuming that any *medicinal* agent existed which, whilst proving innocuous to the host, would destroy, or prevent the sporulation of, the bacillus of tubercle in man.

Discussion.

The PRESIDENT remarked upon the great value of Dr. Hunter Mackenzie's paper, and the careful experiments described therein.

Mr. LENNOX BROWNE ventured to differ from the author of the paper as to the small effect of certain medicinal agents. He had found it possible to destroy the bacilli without hurting the tissues of the host, and had obtained very favourable results from the use of menthol and lactic acid. His colleagues would bear him out in the statement that there had been distinct improvement in cases treated by lactic acid ; and in one case which had been seen by many acute diagnosticians (so that there could be no doubt as to its nature), they had good reason to believe that they had entirely destroyed the bacillus. He was not prepared to admit entirely that the bacillus was the cause of the disease, but in curing the bacilli they had in this case cured the disease. Cases had been recorded by Rosenberg and others, which showed that menthol had a distinct power of controlling the disease. It did not act as lactic acid, but by causing a stimulus to healthy growth. A case which he had in the hospital, of a man with undoubted pulmonary phthisis, had been treated daily with lactic acid with the effect of entirely removing his pain, and accomplishing cicatrisation. He was glad to find that Dr. Mackenzie had such a disbelief in iodoform. He himself thought that iodoform was of little value, and he had ceased to use it. He thought that clinical experiments might contradict, and certainly did not always confirm, laboratory experiments.

Dr. ORWIN had been in the habit of using lactic acid. When in Berlin he had had the opportunity of seeing Dr. Rosenberg's menthol treatment, and he had himself tried it, but had experienced disappointment with the results. He hoped that Dr. Mackenzie would give lactic acid an exhaustive trial. He had recently treated a case by daily applications of lactic acid, with remarkable improvement, where other remedies had failed, and he placed great faith in the treatment of laryngeal phthisis by this means.

Dr. HUNTER MACKENZIE remarked that the previous speakers did not appear to have apprehended the scope of his experiments. His paper was not one upon the treatment of disease, but upon the relative value of the application of certain medicinal agents. He purposely reserved for future discussion the indications for surgical treatment in laryngeal phthisis. He considered that all scraping and scarifying methods were of this character, and was inclined to think that any advantage or benefit derived from recent methods of lactic acid treatment, was largely due to the scraping, &c. He might say that he had employed both lactic acid and menthol, but had not been satisfied with the results. He had wished in his paper to purposely avoid speaking of the results of what he would call surgical treatment of laryngeal phthisis.

Cancer of the Thyroid Gland. By R. NORRIS WOLFENDEN, M.D.

THIS was a clinical paper based upon a study of all the recorded cases of cancer and sarcoma of the thyroid gland. The author thought that cancer of the thyroid was comparatively rarely met with, and that it was

universally admitted to be difficult of diagnosis in its earlier stages, when its recognition could be advantageously followed up with surgical treatment. The author had had under his own care three cases, and had seen two others by the courtesy of his colleagues at the Throat Hospital. The etiology of the condition was dealt with. Though met with at all ages, even in young children (five and a half and seven years by Demme), and in advanced age (seventy-four, Kocher and Kolaczek), cancer appears to be commonest between the ages of forty and sixty. Traumatism had been thought in a few cases to be the determining cause, but most cases developed out of pre-existing goitres, the reason for which was obscure, though possibly connected, as Wölfler suggests, with the process of vascularisation. Sarcoma developed much more rapidly as a rule than carcinoma. The occurrence of malignant tumours of the thyroid in lower animals was noted, and its association occasionally with cretinism and myxœdema.

The author adopted Wölfler's pathology of malignant adenoma, in which metastatic deposits occurred in distant organs (Cohnheim, Wölfler, Coatts, Morris); *Carcinoma*, of which several varieties had been described, and of which the alveolar variety was the commonest, the scirrhous, cylindrical, and epithelial being rarer; and *Sarcoma*, of which the spindle-celled variety was perhaps the commonest. The symptomatology was dealt with at great length, most reliance being placed upon the rapid growth of the tumour, its association with pain, its fixed position on deglutition, the adherence of the skin (which showed that metastasis had already occurred) the pressure symptoms associated with compression of the trachea and œsophagus, and the tendency of the growth to extend deeply in a backward direction. The various symptoms produced by pressure upon blood-vessels, the formation of thrombi, the results of pressure upon nerves (sympathetic, laryngeal, vagus, brachial, &c.), the dissemination of metastases in the different body organs were minutely discussed, and it was shown that these metastases usually occurred at an early period, even before definite diagnosis could be made of the local condition. The treatment was regarded as unsatisfactory, and the palliative operation of tracheotomy was shown to have precipitated the fatal end in many cases. Extirpation was equally unsatisfactory, not being decided upon in the majority of cases until too late to be of any use. Sarcoma was regarded as a "*noli me tangere*."

A paper was also read on *A Case of Nasal Calculus*, by Dr. J. M. Hunt (Liverpool).

Short Notes of a Case of Nasal Calculus of Twenty-three Years' Standing. By H. BENDELACK HEWETSON (Leeds).

ABOUT nine months ago the author saw a gentleman, twenty-seven years of age, in consultation with Dr. Green, of Settle, Yorkshire. He was a hale strongly-built dalesman, but complained that he had a "polypus" in his left nostril, which bled when he touched it, and bits of grit came away. He also suffered from sick headache, and was hardly ever free from pain in the left frontal region. Examination with a probe discovered a large calculus encysted in the centre of a polypoid mass, occupying the left nostril, which at first sight looked very like malignant disease. Ether

was administered, and the stone extracted piecemeal, after crushing with bone forceps, and the polypoid matter scraped freely away. This was followed by iodoform insufflations and antiseptic douches. The stone has a small piece of baby's bottle tubing as a nucleus, and his mother feels sure it got there about twenty-three years ago. She can remember the nostril being stopped since then more or less. The nose and left cheek were swollen, the parts having evidently grown round the calculus. He had not sought advice previously, thinking this a natural deformity; but can remember at school a piece of the same material coming away. The case got on well, and both headaches and sick headaches have entirely disappeared. The calculus was exhibited.

On the Physics of Certain Nose and Throat Diseases. By GREVILLE MACDONALD, M.D.

THE existence of hypertrophic conditions in the nose, apart from inflammatory products, and in structures so different as lymphoid tissue, venous sinuses, cartilage, and bone make it probable that some common cause for this hypernutrition may be found. Most of these appear to arise as a consequence of some temporary or permanent stenosis of the nasal fossæ. Such stenosis during nasal inspiration necessarily implies a lessened barometric pressure within the lungs and all adjoining cavities, this being plainly manifested by the falling in of the upper half of the anterior triangles, and exaggerated descent of the larynx during inspiration. Now patients with partial nasal obstruction, nevertheless, instinctively breathe through the nose as long as they are able; in other words they suffer from an abnormally low air-tension in the nasal and other cavities. Granted the last statement, and it follows, on physical laws, that all the blood-vessels lining these cavities will be over filled, and so will nourish the structures supplied to an exaggerated degree; hence the hypertrophies under discussion. Upon the same physical law may be explained the œdema of the hypertrophied inferior turbinated body, as well as not only ecchondroses, &c., but even simple deflections of the septum; seeing that the latter, if increased from hypertrophy in its vertical diameter, must necessarily, lying between fixed limits, be bowed to one or the other side.

The PRESIDENT (Sir Morell Mackenzie) said he had a highly interesting case to show the Society. It was a peculiar case of a very large growth attached to the lower part of the pharynx. This disappeared under ordinary circumstances, but while he was being spoken to it suddenly darted out of the mouth projecting as a large tumour. It caused very little inconvenience.

An Exhibition of Instruments and Appliances used in the diagnosis and treatment of diseases of the throat and nose was given by the following firms:—Messrs. Weiss, Mayer & Meltzer, Coxeter, Schall & Thisleton. Messrs. Stern also exhibited their well-known preparations of Pumilio.

A number of Pathological Specimens and Microscopic Sections were exhibited by Mr. Walter Fowler, and Microscopic Drawings of Laryngeal Neoplasms were exhibited by Drs. Norris Wolfenden and Sidney Martin.

London: Pardon & Sons, Printers, Wine Office Court, Fleet Street, E.C.

SERIAL

The Journal of Hygiene
and Its Problems

H
I
57
v.2

UMBERGTS